IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

NO. _____

YOKAMON LANEAL HEARN,

Petitioner,

v.

RICK THALER
Director, Texas Department of Criminal Justice
Institutional Division,

Respondent.

EXHIBITS TO PETITION FOR A WRIT OF HABEAS CORPUS (Capital Case)

Volume 1

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EXHIBIT 1

CAUSE N0. F98-46232-S

THE STATE OF TEXAS	§	**IN THE 282ND JUDICIAL**
	§	
VS.	§	**DISTRICT COURT**
	§	
YOKAMON HEARN	§	**DALLAS COUNTY, TEXAS**

ORDER SETTING EXECUTION DATE

The Court has reviewed the State's Motion to Set Second Execution Date and finds that the motion should be granted; and whereas

The Defendant, Yokamon Hearn, was previously sentenced to death by the Court in the presence of his attorneys; and

There being no stays of execution in effect in this case, it is the duty of this Court to set an execution date in the above numbered and styled cause, and the Court now enters the following **ORDER:**

IT IS HEREBY ORDERED that the Defendant, Yokamon Hearn, who has been adjudged to be guilty of capital murder as charged in the indictment and whose punishment has been assessed by the verdict of the jury and judgment of the Court at Death, shall be kept in custody by the Director of the Texas Department of Criminal Justice, Institutional Division, until the **18th day of July, 2012**, upon which day, at the Texas Department of Criminal Justice, Institutional Division. at some time after the hour of six o'clock p.m., in a

room arranged for the purpose of execution, the said Director, acting by and through the executioner designated by said Director, as provided by law, is hereby commanded, ordered and directed to carry out this sentence of death by intravenous injection of a substance or substances in a lethal quantity sufficient to cause the death of the said Yokamon Hearn until the said Yokamon Hearn is dead. Such procedure shall be determined and supervised by the said Director of the Texas Department of Criminal Justice, Institutional Division.

The Clerk of this Court shall issue and deliver to the Sheriff of Dallas County, Texas, a Death Warrant in accordance with this Order, directed to the Director of the Texas Department of Criminal Justice, Institutional Division, at Huntsville, Texas, commanding him, the said Director, to put into execution the Judgment of Death against the said Yokamon Hearn.

The Sheriff of Dallas County, Texas is hereby ordered, upon receipt of said Death Warrant, to deliver said Warrant to the Director of the Department of Criminal Justice, Institutional Division, Huntsville, Texas.

SIGNED this 25 day of April, 2012.

ANDREW CHATHAM, JUDGE
282ND JUDICIAL DISTRICT COURT
DALLAS COUNTY, TEXAS

ORDER SETTING EXECUTION DATE

Hearn/ose
Original

EXHIBIT 2

she runs into street when a car drives up / that car backed up / ~~[illegible]~~ a 2nd car came up + W begged them to stop / they took her to get help / Camp Wisdom + Westmoreland is the major intersection H

Cross X

Never saw photos or line up / described big gun as a rifle to police / gave police a false address – just nervous she says / was living at Dallas Life Foundation / had been living in shelters / denies no psychiatric illness

12/11/98

I am out of the courtroom during the morning working on our witnesses or punishment. I have no notes on that testimony. Wayne Stuff handled those witnesses.

Punishment

CPS ~~workers~~

~~Broadnax~~ Officer Hamby DSO

~~Mrs. Presley~~

Susan Johnson (mother)

Wanda Bell (aunt)

things to do on them:

1. go by snatch scene + place where body dumped — Wayne — Bill that
2. look at videotape from 7-11
3. call Brad Lollar — talk to Delvin Dyles
4. get a copy of Delvin Dyles statement to police + this writing seized from jail cell?
5. get mother of Δ subpoenaed
6. get CPS caseworker subpoened
7. get Δ to Wanda Bell subpoened
8. run down Teresa Shaven Shirley (co-Δ) filed in McDaniel court - Elizabeth Davis appointed - 2 EOI in jail now she is in jail according to Leigh Oatman.
9. run down info on extraneouses / bad acts

Wbol 98 filed T98-70127 203rd granted 12/10/98 to 99 BI

Brad Lollar

Dwight Burley > Dyles says the 2 saw it
+ Sharon

Dyles told Jason that Δ had bragged about killing a guy in Ft. Worth.

10. psychiatrist? — No
11. pick up pre trial transcript

Dwight Burley address:

Inca & 52nd. 5 or 6 houses up from this intersection on Inca. House has carport on front with blue trim on carport. has high hedges on right side of house. On other side of hedge is old white car with gray spots on flat. All 4 tires

in

EXHIBIT 3

CAPITAL SENTENCING STRATEGY:
A Defense Primer

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20TH ANNUAL ADVANCED CRIMINAL LAW COURSE

JULY 25-28, 1994

DALLAS, TEXAS

BB

The Court of Criminal Appeals has never held that the evidence of future dangerousness was legally insufficient because the mitigating evidence of the defendant's character, background and record would have persuaded any rational jury that he will not commit violent acts in the future. In Felder v. State,[117] the evidence at the defendant's second trial for a capital murder showed that he was convicted of three burglaries before he stabbed the deceased during a robbery to prevent her from identifying him, but there was no evidence that he had committed a single violent act during the 12 years that had elapsed since he was arrested for that capital offense. The Court of Criminal Appeals held that the evidence was sufficient to prove that Felder was a continuing threat to society in spite of this because he did not introduce any affirmative proof of his nonviolent record in prison.[118]

III.

INVESTIGATING THE PUNISHMENT PHASE OF A CAPITAL TRIAL

With this information regarding the Texas sentencing structure, and what you can expect from the State on the future dangerousness inquiry, it is critical that you meet their fire with your consoling waters. In the current death penalty statute, the vehicle given by the legislature to combat the State's future dangerousness tool is:

> whether, taking into consideration all of the evidence, including the circumstances of the offense, the defendant's character and background, and the personal moral culpability of the defendant, there is a sufficient mitigating circumstance or circumstances to warrant that a sentence of life imprisonment rather than a death sentence be imposed.[119]

As this special issue implies, everything about the circumstances of the underlying offense (or other prior bad acts), the defendant's character, and the defendant's record (read "history") is relevant to the jury's final determination of this issue. Therefore, this section is designed to present an initial list of essential people to talk to and records to obtain. Each person and document will have information that will lead to additional people and records that you will need to talk to or obtain. Each case will have its own unique set of records, people and events to investigate. This list is best used as an inspirational guide intended to provoke your own ideas for avenues of inquiry.

A. Life History Investigation

1. A thorough intergenerational life history must be developed, incorporating all life history documents and interviews with all first and second degree relatives, friends, peers. As relatives with histories of relevant physical illness (diabetes, endocrine/hormonal, and neurological) and mental illnesses are

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[117] 758 S.W.2d 760, 771 (Tex. Crim. App. 1988).

[118] 758 S.W.2d at 771. The federal constitution allows the state to place the burden on the defendant to introduce mitigating evidence of his law abiding or nonviolent record in a capital sentencing trial, Delo v. Lashley, 507 U.S. ___, 113 S .Ct. 1222 (1993), but the Supreme Court has not decided whether this rule applies in reviewing the sufficiency of the evidence of a statutory aggravating circumstance issue like future dangerousness that the state must prove.

[119] See Art. 37.071(2)(e), V.A.C.C.P (Vernon Pocket Part 1993).

identified, obtain their medical and life history documents.

- Where were grandparents and parents from? How did they support themselves through the years?
- What kind of housing, medical care, nutrition, and education did grandparents and parents have?
- Find the folks (aunts, cousins, neighbors) who knew that sexual, physical, or psychological abuse occurred in the family.
- Investigate anyone who had the opportunity to abuse your client in any way. If parents worked, investigate the people who cared for your client and had access to him.

2. Find schoolmates, cousins, neighbors, or others -- including family members and caretakers -- who would have known your client and/or the family during his developmental years. Check for:

- Nightmares, sleep disturbances, fear of the dark;
- Rocking, biting, head banging during early childhood (Look at symptoms of Pervasive Development Disorder in Psychiatric Textbook, 5th edition);
- Withdrawal, quietness, shyness;
- Peculiar concern about food, weight loss;
- Difficulty reading, speech impediments;
- Anxiety, nervousness, crying, hiding;
- Superstitions;
- Fears, responses to crises.

3. Birth Certificates. Get birth certificates for your client and all family members. Family includes siblings, parents, step-parents, grandparents, children, spouse, significant other. Birth certificates are available from the Department of Vital Statistics in each state -- some states require a signed release. Be sure to obtain from your client and each member of her family signed releases for this and for other records listed below. You will need each person's full name, birth date, social security number and any other names previously used.

4. Birth records. Obtain birth records from hospital, doctors, midwives. This includes prenatal (i.e., the mother's) and birth (i.e., the client's) records. You will need these records for your client as well as all siblings.

5. Obtain a thorough pregnancy history with mother for each child: drugs, alcohol, beatings/physical abuse, accidents, bleeding, nutrition, edema, nerves, sleep patterns, length of labor, anesthetic during labor, forceps, any trauma, home remedies, nausea, weight gain/loss. This will complement the prenatal and birth records you receive.

6. Church records. Did your client go to Church? Is so, what church? Do they have records? Were there people in the church who remember him and things about it? Interview these people.

7. School records. Get all school records for your client, his parents, siblings and children. Check with each school attended as well as the school board. Ask the school board and each school if outside private or public agencies conducted psychological evaluations or special testing. Contact those agencies and obtain their records. Review school yearbooks and publications and copy all pages related to your client or a family member.

8. Adult Education Records. Obtain all adult education records on your client. Check with Job Corps, Urban league, private agencies, community colleges, GED programs, vocational programs.

9. Locate teachers and counselors who remember your client and/or his family. Talk to them.

10. Childhood photographs. Ask family, relatives, friends for these.

11. Were the homes he lived in near industry -- what toxins was he exposed to through his environment?

12. Medical records. Get all of your client's, your client's parents', siblings', spouse or significant other's, and children's medical records for any hospitalization or hospital, public and private clinic or doctor's office treatment. Check every hospital for every person regardless of whether anyone a family member was treated there. Separately check at each emergency room in every geographic area where your client lived. Ask specifically for films of x-rays, CT scans, MRIs as well as narrative reports.

13. Mental health records. Has a psychiatric evaluation ever been made of your client or anyone in her family? If so, get all records, including any testing, raw data, interview notes, tapes, photos, preliminary reports, memos from attorneys, and any material whatsoever in file. If any person was hospitalized involuntarily, obtain the court records and talk to the attorneys involved.

14. Talk to your client and family members about any history of mental illness, mental retardation, physical illnesses or disability in the family? If so, get records. Find out from your client and family members the names of family doctors, dates of hospitalization, etc. Talk to the family doctor or any other doctor who treated the family member.

15. Has your client, or anyone in his family ever tried to commit suicide? Document any occasion and get thorough history. Are there police records? Hospital/ER records?

16. Death Certificates. Get death certificates for any close family members who have died. Obtain all related medical and hospital records, the autopsy report and the obituary.

17. Work records. Get any work-related records available. Look especially for injuries, worker's compensation, performance evaluation, salary. Talk to former employers and co-workers, especially those who worked with your client prior to the offense.

18. Police response calls and incident reports. Check police files for any incident reports and dispatches to parents' home and any other place where your client lived. Look for domestic disturbances, alcohol or drug-related incidents, bizarre conduct by parents or caretaker, visitors.

19. Jail, court, and police records for offenses by family members. Obtain these records on all arrests and convictions for your client's family -- parents, siblings, children, spouse, significant other, etc. This includes attorney files for any attorney who represented any of these persons at trial, on appeal, in collateral proceedings, etc. Check for records at any place that the family has lived. Jail records

should include classification reports, psychological reports, medications administered, disciplinary reports, medical records, visitor logs, etc.

20. Civil Proceedings. Check all civil court proceedings to see if your client or parents were sued or sued anyone including divorce proceedings initiated and abandoned or completed. Obtain all child support orders, custody decrees, and peace bonds/temporary restraining orders. Get the attorney files on any divorce (from both parties if possible).

21. Marriage Certificates. Get marriage certificate for client, parents and grandparents. This includes previous and subsequent marriages.

22. Social service agencies. Was your client's family ever on welfare or some other form of government aid. Check with social services to see if family has any records or reports for neglect, abuse, special needs. Obtain home study reports, referrals and results of testing or counseling, intervention, placement in foster home, termination of parental rights. Check this information for client, siblings, parents, children.

23. Texas Youth Commission. For your client and all siblings obtain records, reports, evaluations, tests including counseling conferences, intervention reports, foster placement records, any other form of treatment or placement.

24. Juvenile courts and facilities. Obtain all juvenile court records for your client and siblings. You may need a court order. Check each juvenile facility in every state your client lived for all medical, intake, evaluation, disciplinary and school records.

25. Parole and probation. Get all parole and probation records, including juvenile. Check with the local parole office as well as regional and central offices.

26. Private social service agencies. Check with Catholic Social Services, private juvenile shelters, Big Brothers, Boys' Clubs and other private agencies for any records on your client, siblings, or family.

27. Military records. Obtain complete file for client and any family member. If a parent served in the military, also obtain all medical and school records the military has for your client.

28. Jail, court, and police records for client's prior offenses. Obtain these records on all arrests and convictions for your client. Check for records at any place that the family has lived. This includes:

a. Attorney files for any attorney who represented your client at trial, on appeal, in collateral proceedings, etc. ((Use a release signed by your client which includes the release of all work product);

b. Jail records (classification reports, psychological reports, medications administered, disciplinary reports, medical records, visitor logs, etc.);

c. Public court records;

d. Prosecutor's file;

e. News clips about your client and the offense;

f. For every co-defendant, court, prosecutor, jail, attorney records.

If any priors involved a police officer, obtain that officer's personnel file, the internal affairs division

investigation and report, and the citizen review board report.

29. What is your client's alcohol, drug history, including when he first inhaled glue, organic solvents, gasoline, freon, paint, paint thinner, etc. The drug/alcohol history needs to be as detailed as possible: age first used, amount, frequency, circumstances, street name, effect on behavior, physiological effects. This needs to be done with particular detail for the few days prior to and including the offense.

30. Develop a diet (including alcohol and drugs) history of your client for week of offenses. What did he eat, when, how much? When did he sleep -- how many hours, where. What was his sleep pattern around time of offenses. Did his weight fluctuate? How much time was there between the death in his family and the offenses?

31. Prison records. Get the Texas Dept. of Criminal Justice files for prior incarcerations. Include administrative, classification, employment, educational, and medical, psychiatric, disciplinary records.

B. Trial Investigation

Often, the investigation of the trial issues will itself lead to information necessary to the development of your punishment theory of defense.

1. Attorney files for every attorney who may have represented your client pre-trial, or at a previous trial or appeal if applicable.

2. Prosecution and police files in this case. Make sure that police lab reports, incident reports, witness statements, etc. are included.

3. Jail, court, and police records for this offense. Obtain these records for your client. Jail records should include classification reports, psychological reports, medications administered, disciplinary reports, medical records, visitor logs, etc. Ask for these records by name. If this offense involved a the shooting of a police officer, obtain that officer's personnel file, the internal affairs division report, and the citizen review board report.

4. Autopsy records for all victims. This includes photos, bench notes, tape recordings, memos from prosecution, and any other material whatsoever in pathologist's files.

5. Investigate the medical examiner's background. Sources to contact include professional regulation agency, criminal and civil courts, universities and schools attended, employment records. Compare his testimony about qualifications with actual qualifications. Look for fraud and misrepresentation. Also investigate the qualifications of the pathologists who actually performed the autopsies.

6. Victim Court Records. Check criminal and civil courts for any proceedings involving the victim. Check every county where they are known to have lived.

7. Were any previous attorneys in prior cases disciplined, disbarred, drug abusers, alcoholics?

8. Co-defendants in this offense. Get prior (and subsequent?) criminal records including arrest records, court files, incarceration records, state law enforcement rap sheets, FBI rap sheets. Be sure to check juvenile proceedings and police records.

Obtain court, police and incarceration records for co-defendants on this offense. If the co-defendant was tried, get a copy of the trial transcript. Obtain the attorney file.

C. Developing a Defense Theory of Punishment

Once you have assembled everything -- both information and records -- regarding your client's life, you must create a defense. Although all this may be presented at trial to overwhelm the jury, just as with a guilt/innocence strategy, your punishment strategy will be most effective if it is constructed carefully. Although each case is unique, the most successful punishment strategies seem to perform several functions at once:

1. Humanize your client. Don't just make him out to be a fellow human being, make him out to be a unique human being. Everyone has positive character traits and people who know them to be good and valuable individuals. Present him as someone who, although flawed, is valuable and loved.

2. Do not shy away from negative evidence (mental illness, abuse, drug addiction, etc.). Although your client's past might increase the likelihood of his future dangerousness, you're mistaken if you believe the State won't find it or use it.

3. Use all your mitigating evidence and relate it to the criminal act. Negative qualities are often the primary source of explanatory evidence. For example, in Eddings v. Oklahoma, the defendant's child abuse at the hands of his police officer father was directly linked through expert testimony to Edding's murder of a police officer. Likewise, some people are on death row for acts that they performed out of loyalty to or love of another person.

4. Present a theory that allows the good and bad to coexist in your client. Jurors recognize the potential for evil in themselves and, if properly presented, may understand it in your client.

5. Explain as much as possible. Facts in a vacuum are what prosecutions are made of. They would like to portray the most superficial version of your client as a mean dog who needs to be put down. DON'T LET THEM! If your client is a drug or alcohol addict, explain why he is addicted and when he began using; if your client is schizophrenic; explain why he is mentally ill and why the State previously failed to treat him, if he is loved, explain why and how; if he was previously convicted, explain the surrounding circumstances.

6. Use your witnesses to fully develop the picture of a person who is life-worthy. Present all your witnesses as you would a cohesive alibi or insanity defense -- aim with each piece of evidence toward the telling of a unified vision of your client's value and worth. Psychiatrists, psychologists, other doctors, prison or corrections experts, all can create the ultimate picture of how your client can be productive and helpful even if incarcerated.

Ultimately, you must present a defense that demonstrates and conveys how much you believe that your client should live and why he should not die for the crime for which the jury has just convicted him. These defenses are daily winning in Texas because, as much as people want to have the death penalty, those same people, once jurors, actually do think long and hard before sentencing a fellow traveler to die.

EXHIBIT 4

HP-9
VIOLATOR OR SUSPECT

TEXAS DEPARTMENT OF PUBLIC SAFETY
DWI/DUID TRAFFIC CASE REPORT

1126

County COLLIN State TEXAS

NAME ROSS TIMOTHY MILTON (Last, First, Middle) Address [redacted] DL No. [redacted] Birth Date [redacted] Sex M Race N

Height 6' Weight 175 Occupation TRUCK DRIVER Driver and Criminal Record

VEHICLE: Color TURQUOISE Year Model 1959 Make CHEV. Body Style PICKUP Registered 71 (Year) TEXAS (State) (Number) ☐ A.M.

OFFENSE D. W. I. ☐ Fatal Accident ☒ Non-Fatal Accident ☐ No Accident Date 1 – 8 – 19 72 Day of Week SATURDAY Hour 8:15 ☒ P.M.

ROAD ON WHICH OFFENSE OCCURRED PARKER RD. AT S.H. 5 (Name of Street or Highway No.) 1100 BLK. (Section) ☒ In, or ☐ N ☐ E ☐ S ☐ W of PLANO (Town or City)

WITNESSES	Elements of this case witness can testify to	Subject Driving Motor Vehicle: On Public Highway	Subject Driving Motor Vehicle: In Incorp. City (MTOH)	Intoxicated or Under Influence of Drugs	Person Killed Due to Accident	Accident Occasioned by Intoxicated Condition of Subject
BILLY JOE RICHERSON [redacted] (Name)		YES	YES	YES	NO	YES
MIKE WHITEHEAD (Name) PLANO POLICE DEPT. (Address)				YES		

CHEMICAL TEST
Test Offered ☒ Breath ☐ Urine ☐ Blood ☐ None ☐ Other, specify
Test Given ☒ Breath ☐ Urine ☐ Blood ☐ Refused ☐ Other, specify
Refusal form Submitted ☐ Yes ☐ No
Test Result .20 %
Officer/Operator: JOHNNY MOCK, SGT., PLANO P.D. 15 (Identification No.)

ARRESTING OFFICER MIKE WHITEHEAD Ident No. 75 Dept. PLANO POLICE DEPT. Other Officers

OBSERVATIONS
CLOTHES – Describe type and color: Hat or Cap NONE; Shirt or Dress GREEN, WHITE, YELLOW PLAID; Jacket or Coat TAN SPORT JACKET; Pants or Skirt GREY KHAKIS
Condition ☒ Disorderly ☐ Disarranged ☐ Soiled ☒ Messed ☐ Orderly Describe

BREATH Odor of Alcoholic Beverage	☒ Strong	☐ Moderate	☐ Faint	☐ None		
ATTITUDE	☒ Excited	☐ Hilarious	☒ Talkative	☐ Careless	☐ Sleepy	☒ Profanity
	☐ Combative	☐ Indifferent	☒ Insulting	☒ Cocky	☐ Cooperative	☐ Polite
UNUSUAL ACTIONS	☐ Hiccoughing	☐ Belching	☐ Vomiting	☐ Fighting	☐ Crying	☒ Laughing
SPEECH	☐ Not Understandable	☐ Mumbled	☒ Slurred	☒ Mush Mouthed	☒ Confused	
	☒ Thick Tongued	☐ Stuttered	☐ Accent	☐ Foir	☐ Good	
BALANCE	☐ Falling	☒ Needed Support	☒ Wobbling	☒ Swaying	☒ Unsure	☐ Sure
WALKING	☐ Falling	☐ Staggering	☒ Stumbling	☒ Swaying	☐ Unsure	☐ Sure
TURNING	☐ Falling	☐ Staggering	☒ Hesitant	☒ Swaying	☐ Unsure	☐ Sure

Fingerprinted By ☐ Not Fingerprinted

Signature of Officer Making Report Mike Whitehead (Name of DPS Officer or Name of Other Police Agency and their File Number) Ident. No. 75 Date of Report 1-8-72 Disposition of Case 5 yrs. TDC probated 1-3-73

INTERVIEW

Were you operating a vehicle? YES Where were you going? OUT TO PARKER What street or highway were you on? PARKER RD.

Direction of travel? EAST Where did you start from? PLANO What time did you start? 9:00 PM What time is it now? 10:05 PM

What city (county) are you in now? PLANO What is the date? THE 8TH What day of the week is it? SATURDAY, RIGHT?

INTERVIEWER TO FILL IN ACTUAL 10:05 (Time) am/(pm) SATURDAY (Day) 1-8-72 (Date) MIKE WHITEHEAD (Interviewer's Name)

When did you last eat? 2:00 PM What did you eat? PLATE LUNCH What were you doing the last three hours? CAME UP HERE FROM DALLAS

Have you been drinking? YES What? BEER How much? 2

Where? DOWN HERE IN COLORED TOWN Started? 8:30 am/(pm) Stopped? 8:50 am/(pm) Are you under the influence of an alcoholic beverage now? NO

What is your occupation? TRUCK DRIVER When did you last work? TODAY Do you have any physical defects? _____ If so, what? _____

Are you ill? _____ If so, what's wrong? _____ Do you limp? _____ Have you been injured lately? _____ If so, what's wrong? _____

Did you get a bump on the head? _____ Were you involved in an accident today? NO Have you had any alcoholic beverage since the accident? NO

If so, what? N/A Where? N/A How much? N/A When? N/A

Have you seen a doctor or dentist lately? _____ If so, who? _____ When? _____ What for? _____

Are you taking tranquilizers, pills or medicines of any kind? _____ If so, what kind? (Get sample) _____ Last dose? _____ am/pm Do you have epilepsy? _____

Diabetes? _____ Do you take insulin? _____ If so, last dose? _____ am/pm Have you had any injections of any other drugs recently? _____

If so, what for? _____ What kind of drug? _____ Last dose? _____ am/pm When did you last sleep? LAST NIGHT

How much sleep did you have? 14 HRS. Are you wearing false teeth? _____ Do you have a glass eye? _____ Other information _____

SUMMARY (Describe what you did and what you found, showing information such as why you started case; — names of owners; — condition of vehicle and defendant; — possession of operator's license, by number; — pertinent remarks of defendant, witnesses, doctors, — physical condition of road, traffic, weather; — disposition of vehicle and defendant.)

WORKED ACCIDENT (MINOR) IN WHICH ARRESTED PARTY WAS A DRIVER, AND BACKED INTO ANOTHER VEHICLE. WHEN SG. TALKED WITH SUBJECT IT WAS APPARENT HE WAS VERY INTOXICATED. SUBJECT WAS VERY BELLIGERENT AND DENIED DOING DAMAGE TO OTHER CAR. OTHER DRIVER STATED HE WOULD TESTIFY TO FACT THAT SUBJECT WAS DRIVING ON PUBLIC STREET AND BACKED INTO HIS CAR. SUBJECT WAS OFFERED AND TOOK BREATH TEST. TEST RESULT .20% SUBJECT PLACED IN CITY JAIL.

IR-140

TEXAS DEPARTMENT OF PUBLIC SAFETY
BREATHALYZER OPERATIONAL CHECK LIST

Subject's Name Ross Timothy Milton (Last, First, Middle) Date 1-8-71

Time (of test) 9:18 PM Blood Alcohol ft. .20 % Ampoule Control No. 74821

Operator Johnny Mack Witness Alice Whitehead

Instrument No. 900-3476 Location McKinney Tx.

Reference Analysis: Predicted 0.18 % Simulator Test 0.17 %

PREPARATION
1. ☑ Throw SWITCH to "ON", wait until THERMOMETER shows 50° ± 3° C.
2. ☑ Gauge TEST AMPOULE and insert in left-hand holder.
3. ☑ Gauge TEST AMPOULE, open, insert BUBBLER and connect to outlet.

PURGE
4. ☒ Turn to TAKE, flush out, turn to ANALYZE.
5. ☒ When RED empty signal appears, wait 1½ minutes, turn on LIGHT, BALANCE.

ANALYSIS
6. ☒ Set BLOOD ALCOHOL POINTER on START line. (.00 line for Simulator Test)
7. ☒ Turn to TAKE, take breath sample, turn to ANALYZE, (record time).
8. ☒ When RED empty signal appears, wait 1½ minutes, turn on LIGHT, BALANCE.

Then for SIMULATOR TEST start at 6 and follow same procedure.

Record answer, dispose of test ampoule, TURN CONTROL KNOB to "OFF"

FBI 674-734 A DPS 664-443

Cell # 4

PRISONER'S JAIL RECORD

ID. NO. 1126

NAME Timothy Milton Ross					SOCIAL SECURITY NO.		DATE 1-8-72	TIME 10:00	A M / P M
[redacted]					OCCUPATION TRUCK DRIVER			WARRANTS	
ALIAS OR NICKNAME					SCARS OR MARKS				
DATE OF BIRTH [redacted]		PLACE OF BIRTH DES MOINE, IOWA			ARRESTING OFFICER MIKE WHITEHEAD				
AGE 45	RACE N	EYES BRN	HAIR BLK	SEX M	HEIGHT 6'	WEIGHT 175	COMPLEXION BLK		
OFFENSE D. W. I.					STATUS				
SENTENCE BEGINS		SENTENCE EXPIRES			HOLD FOR				
HOW RELEASED		DATE	TIME		RELEASING OFFICER				
BEHAVIOR BAD					TIME ALLOWED FOR GOOD BEHAVIOR				
REMARKS									

Currency $ 5.00	Wallet 1	Watch	
Change $ .62	Rings	Knife	
Checks $ -	Keys	Lighter 1	
TOTAL $	Cards	Pen-Pencil 1	

OTHER ITEMS NOT CLASSIFIED: COMB - BELT

VEHICLE INVOLVED 95 Chev F/U	IMPOUNDED 95
CONDITION BAD -	STORED AT KLEVICK'S
SEARCHED BY Mike Whitehead	PRISONER'S ATTORNEY
	CALLED ATTORNEY
OTHER CALLS PERMITTED	

I certify that the above is a correct list of items removed from my possession at the time I was placed in jail.

I hereby authorize the censoring of all my mail by jail authorities. Mike Whitehead

Prisoner X REFUSED

Received all of the above listed property on this _____ day of _____, 19__.

Signature X _____

FORM LE 12
G. A. THOMPSON, BOX 4681,
DALLAS, TEXAS 75208

EXHIBIT 5

```
            Release of Information Display - Display Data Elements

CASE NUMBER: 000029216   HEARN SUSAN D                              ** Inactive
                                    Eff Date
     Display of Release Requests: 03242005  - Record Start -
           Date Request Received: 03242005 03/24/2005
                Requestor's Name: 03242005 RANDI WALL CHAVEZ, LMSW
                  Contact Person: ________ ____________________
              Requestor Address: 03242005 PO BOX 270033
                            City: 03242005 AUSTIN
                           State: 03242005 TX         TEXAS
                        Zip Code: 03242005 78727
     RETURNED INCOMPLETE BECAUSE: ________ ____________________________________
                                : ________ ____________________________________
                                : ________ ____________________________________
       Number of Hard Copy Pages: ________ ____
      Number Micro/Optical Pages: 03242005 20
                   Total Charges: ________ ________
                  Payment Method: ________ __
          Date Request Completed: 03242005 03/24/2005
                    How Shipped: 03242005 02          FIRST CLASS MAIL
     (End Record)                                  -- End Record --

<Enter>=complete, <F9>=abort, <F8>=addt'l data: __
```

This information has been disclosed to you from records whose confidentiality is protected by Federal and State Law. The information may not be redisclosed without specific written consent of the person to whom it pertains.

RANDI WALL CHAVEZ, LMSW
P.O. BOX 270033
AUSTIN, TEXAS 78727
VOICE (512) 873-2331 ~ FAX (512) 873-2346

2926 p02

3/10/2005

Records Department
Mental Health Mental Retardation of Tarrant County
3840 Hulen Street, North Tower
Fort Worth, Texas 76107
Phone No: (817) 569-4300

Re: Records Request for Diane Johnson (AKA Susan D. Hearn, Susan D. Johnson, Susan D. Ross, Diane Hearn, Diane Ross), Social Security #: [redacted] DOB: [redacted]

To Whom It May Concern:

I am writing to request the release of any and all records in your possession pertaining to Diane Johnson (or any alias she may have used). It is my understanding that Ms. Johnson was a resident in the Billy Gregory Detox Center. However, please note that I am requesting records from this center, as well as any other records you may have. Enclosed with this letter are two copies of releases of information. One is HIPPA compliant and the other is a basic release of information. These are appropriate for the records I am requesting.

I would appreciate it if you could send a complete, certified copy of these records to me at the above address. Certification requires a letter on agency letterhead stating that the contained records are true and correct copies of originals in the agency's file. Any associated costs will be paid upon submission of an invoice.

It is imperative that this request be answered as quickly as possible. Please contact me at the above phone number if you have any questions. If email is an option you can contact me at rwchavez@austin.rr.com. Thanks in advance for your assistance in this matter

Sincerely,

Rand Wall Chavez, LMSW

TARRANT COUNTY MENTAL HEALTH
MENTAL RETARDATION SERVICES

Case #: 029216

Client Name: SUSAN HEARN

Unit #: GRAN Bc 251

CPC #: 900

Date of Discharge: 7-3-95

Circle Below if Appropriate:

1 = Moved out of State

2 = Deceased

Enter Date and Time of Move or Death

M M D D Y Y

H H M M A/P

DISCHARGE SUMMARY

I. Reason for Discharge
II. Presenting Problems
III. Description of Services Course and Results
IV. Referral, information, and recommendations made to client
V. Planning/linking activities
VI. DSM III-R Discharge Diagnosis/ABL
A. Admission Diagnosis (Axes I-V)
B. Discharge Diagnosis (Axes I-V)
C. ABL (Mental Retardation Clients only)

(Use Addendum pages as needed - signature and date on last page)

I. Ct completed 28 day Chemical Dependency treatment program at Pine Street.
II Alcohol Dep. 303.90, Cocaine Dep. 304.20 & Cannabis Dep. 304.30
III Ct will learn of the unmanageability of her disease through her involvement in recovery. Ct will have the opportunity to see herself as others see her by her peer evaluation.. Ct was given a Chance to grow spiritually through her Spirituality in recovery. Ct was educated on HIV/STD, and Relapse. Ct started AA/NA and began developing a network of a personal sober Support System. Ct was not worked in a Variety of 12-Step meeting
IV MHMR-Homeless Outreach for Housing
V AA/NA, Pine Street after Care referral back to referral Source MHMR-Homeless outreach.
VI A - I Alcohol Dep 303.90, Cocaine Dep 304.20, Cannabis Dep 304.30
II NO DX V71.09
III NONE
IV ACDEC
V 45/45
B - I, II, III IV all the Same — AXIS V 48/60

Brenda Clemmons C.I. 7-12-95
CPC/CM Signature/Title/Date

SC Hansen PM 7/13/95
Supervisor Signature/Title/Date

Rev. 3/94
S-002-1

T

029216
Susan Hearn
DOB: [redacted]
SS# [redacted]
05/23/95

INTERIM TREATMENT PLAN

Case Number	Today's Date (mm dd yy)	Next Staffing Date (mm dd yy)	CPC Number
029216	05/23/95	07/07/95	646

Principal Diagnosis Axis (Circle One): Axis I Axis II

Axis	Level	Diagnosis	DSM / ICD Code
Axis I	Level 1	Alcohol Dep.	
	Level 2	Cocaine Dep.	
	Level 3	Cannabis Dep.	
Axis II	Level 1	No Dx	V71.09
	Level 2		
	Level 3		
Axis III	Level 1	None	—
	Level 2		
	Level 3		

Axis IV: ALDEBT Axis V Current: 45 Prior Year: 45 MR Only, ABL Current: Potential: CM/OBRA ONLY, Svc Need Level:

Primary Problem Category: MH (DRUG) ALCOHOL MR DD/ECI MR SERVICE CATEGORY:

Interim Treatment Plan (Good for 45 days; Unless discharged from state facility, then this is only valid for 21 calendar days- Community Standard 6.9P)

I. Ct. will experience a state of detoxification from EtOH [illegible] w/minimal signs + symptoms of withdrawal w/in 11 days.

II. Ct. will demonstrate ↑ increase of desire for physical wellness w/in 2-3 days of admin by participation in groups.

III. Ct. to be given addiction severity index by Caseworker to determine treatment issues to be addressed. DK date
ASI Completed by Caseworker on: 5/31/95

IV. Ct. to gain knowledge of basic recovery concepts through groups.

V. Ct. to gain knowledge of HIV/Std's through HIV/Std's Educational groups.

Describe Planning/Linking activities needed:

AA/NA aftercare, MH/MR (CATS) Pine St. admit date: 6/12/95

Summarize the discussion with client regarding client fee and client responsibility:

financial screening to admit, finds ct. medically indigent @ this time, ct pays registration fee only

Susan D. Hearn — Client Signature

[signature] LCDC — CPC/Case Manager Signature Unit # 250 Date: 5/23/95

Parent/Legal Guardian (if applicable) Psychiatrist Signature Unit #______

[signature] #250

Other Signatures (include relationship to client or Unit #)

If client does not sign, state reason:______

Model 7/1/93
S-004-3-I

Distribution: Original- Chart Yellow Copy- Client Accounting Pink Copy- Client

029216
Susan Hearn
DOB: [redacted]
SS#:
06/05/95

EATMENT PLAN

Problem #

Case Number	Today's Date	Next Review Date*	CPC Number
029216	6 (mm) 13 (dd) 95 (yy)	7 (mm) 11 (dd) 95 (yy)	900

[redacted]EM OR CRISIS SITUATION: My needs or problems that I am here to work on. My Drug addiction
Ct lacks of Chemical Dep. Hx Assistance.

THIS PROBLEM WAS IDENTIFIED ON THE LAST MULTIDISCIPLINARY ASSESSMENT DATED: 5 31 95 (Assessment must be updated every two years).

MY STRENGTHS: The things I can do to solve the problems. "Determined", "willingness to learn"

GOAL(S) OF TREATMENT: I would know that my situation was better when/if (Specify behaviors/feelings in measurable outcomes with time frames)
① Ct will write about her powerlessness over cocaine & alcohol and read in Group.
② Ct will write about spirituality in recovery and present to group. Ct will Develope a Sober Support System by attending 3 open AA meetings

SERVICE TYPE/TARGETED INTERVENTION/RESPONSIBLE STAFF: (Ind. counseling, Med. Maint., etc): Include frequency/duration and focus of intervention for each service. Note staff responsible for each service type.
Case worker will provide gp therapy 1X a week for length of episode
Cw. will provide written assignments for Ct to Complete during Next 2 weeks
Cw. will provide 1:1 Counseling weekly.

THE TREATMENT TEAM CONSIDERS THIS PROGRAM APPROPRIATE TO MEET THE CLIENT'S TREATMENT NEEDS.

Is client due for a physical exam? ☐ Yes ☑ No. If "Yes," identify plan:

I have participated in developing my plan of treatment. It has been explained to me in simple non-technical language. Possible adverse effects of the treatment and rejecting treatment have been explained to me. I agree to participate in and cooperate with treatment. I understand that I may withdraw this agreement at [redacted]me.

X [redacted] Diane Hearn — Client Signature | NB — Parent/Legal Guardian (if applicable) | NB — Psychiatrist Signature and Unit # | 6-13-95 — Date

[redacted] 251 — CPC/Case Manager Signature and Unit # | Other Signatures:

Other Signatures (include relationship to client or Unit #)

If [redacted] does not sign, state reason:

TREATMENT PLAN REVIEW DATE: ___/___/___ NEXT STAFFING DATE*: ___/___/___ (*Not to exceed 90 days)

PROBLEM: (Circle One) RESOLVED DELETED CONTINUED

EFFECTIVENESS OF INTERVENTIONS:

CHANGES TO SERVICE TYPE/TARGETED INTERVENTION/RESPONSIBLE STAFF:

Client Signature | Parent/Legal Guardian (if applicable) | Psychiatrist Signature and Unit # | Date

CPC/Case Manager Signature and Unit # | Other Signatures:

[redacted]ignatures (include relationship to client or Unit #)

If client does not sign, state reason:

* Not to exceed 90 days

Rev. 6/94
S-004-2-I

Distribution: Original- Chart Yellow Copy- Client (90 Day Review) Pink Copy- Client (Initial Plan)

INITIAL PLAN

REVIEW / UPDATE

TCMHMR Services
Addiction Services Division
Interpretive Summary

029216
Susan Hearn
DOB [redacted]
SS#: [redacted]
05/23/95

Clinical Impressions (Include relevant cultural/ethnic issues/ summarize all assessments)

Ct is a 34 y/o Black female ē presenting problems of Crack cocaine & alcohol, ct quit school at early age and got married, has son 16 y/o that gives her lot of problems, ct attempted suicide 3 times [illegible] in and out of hospitals, ct states this was due to [illegible] [illegible] y/o. Ct stated she felt no one loved her, after her (M) & (F) died ct stayed depressed. ct has bad relationship ē (S) ct (F) was alcoholic ct's [illegible] & son 16 y/o was taken and CPS has him. ct stated she is homeless had been living in the Night Shelter when she got in to fight ē a person there and was sent to jail. Ct need lot of work on her self esteem, has [illegible] problems will try to link ct ē homeless outreach before D/C.

029216
Susan Hearn
DOB: [redacted]
SS#: [redacted]
06/05/95

[redacted]

List Weaknesses [Consider: impulsive, needs conflicts, distractions, etc.]
impulsive (in the past), her Son, my attitude

Treatment Length/Intensity (Describe fully any variance) 3 to 4 wks Int. & A.

[redacted]

[redacted]

What does client feel are his/her strengths/weaknesses?
Mark blank column using either "S" or "W" or "N/A."

W	Education	W	Social lifestyle	W	Finances		Other
W	Employment	W	Spouse/Sign. Other	S	Spirituality		
W	Family	S	Health	S	Friends		

[redacted] life

Summary of input from family, friends, and significant others:
Not yet obtained

[redacted]

[redacted]

Signature/Title Butch Clemmons C.S. Unit# 251 Date 6/13/95

029216
Susan Hearn
DOB: [redacted]
SS#: [redacted]
05/23/95

Tarrant County Mental Health Mental Retardation Services

Addiction Severity Index, Fifth Edition

GENERAL INFORMATION

ID No.: 02921 6

SS No.: [redacted]

Date of Admission: 05 / 23 / 95

Date of Interview: 05 / 31 / 95

Time Begun: HOUR: MINUTES 01 : 30 am

Time Ended: HOUR:MINUTES 02 : 30 pm

Class: 1. Intake 2. Follow-up 1

Contact Code: 1. In person 3. Mail
2. Telephone (Intake ASI must be in person) 1

Gender: 1. Male 2. Female 2

Treatment Episode No.: 02

Interviewer Code No.: 646

Special: 1. Patient terminated 2. Patient refused 3. Patient unable to respond N

Susan Hearn
Name
(PNS) [redacted]
Address 1
Address 2
City State Zip Code

1. How long have you lived at this address? (Years/Months) -- / 05

2. Is this address owned by your or your family? 0-No 1-Yes 0

3. Date of birth: (Month/Day/Year) [redacted]

4. Of what race do you consider yourself? 2
1. White (not Hisp) 5. Asian/Pacific 9. Hispanic-Other
2. Black (not Hisp) 6. Hispanic-Mexican
3. American Indian 7. Hispanic-Puerto Rican
4. Alaskan Native 8. Hispanic-Cuban

5. Do you have a religious preference? 1
1. Protestant 3. Jewish 5. Other
2. Catholic 4. Islamic 6. None

6. Have you been in a controlled environment in the past 30 days? 2
1. No 4. Medical Treatment
2. Jail 5. Psychiatric Treatment
3. Alcohol/Drug Treat. 6. Other: _____
> A place, theoretically, without access to drugs/alcohol.

7. How many days? 01
> "NN" if Question No. 6 is No. Refer to total number of days detained in the past 30 days.

App. 2/94
E-002-1

ADDITIONAL [illegible]

PROBLEMS	SEVERITY PROFILE									
	0	1	2	3	4	5	6	7	8	9
MEDICAL		X								
DRUG/SED					X					
ALCOHOL								X		
DRUGS								X		
LEGAL				X						
FAM/SOC							X			
PSYCH							X			

GENERAL INFORMATION COMMENTS

(Include the question number with your notes)

#1 Cl. has been living in the night Shelter.

MEDICAL STATUS

1. How many times in your life have you been hospitalized for medical problems? [2]
   >Include O.D.'s, D.T.'s. Exclude detox, alcohol/drug, and psychiatric treatment and childbirth (if no complications). Enter the number of overnight hospitalizations for medical problems.

2. How long ago was your last hospitalization for a physical problem? [1][4] Yrs. / [0][0] Mos.
   >If no hospitalizations in Question 1, then this should be "NN".

3. Do you have any chronic medical problems which continue to interfere with your life? 0 - No 1 - Yes [1]
   If "Yes" specify in comments.
   >A chronic medical condition is a serious physical or medical condition that requires regular care, (i.e., medication, dietary restriction) preventing full advantage of their abilities.

3b. <OPTIONAL> Number of months pregnant: [0] Mos.
   >"N" for males, "0" for not pregnant.

4. Are you taking any prescribed medication on a regular basis for a physical problem? If yes, specify in comments. 0 - No 1 - Yes [0]
   >Medication prescribed by a MD for medical conditions) not psychiatric medicines. Include medicines prescribed whether or not the patient is currently taking them. The intent is to verify chronic medical problems.

5. Do you receive a pension for a physical disability? 0 - No 1 - Yes [0]
   >Include Workers' compensation, exclude psychiatric disability.
   If "Yes" specify in comments.

6. How many days have you experienced medical problems in the past 30 days? [0][0]
   >Do not include ailments directly caused by drugs/alcohol. Include flu, colds, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, abscesses from needles, etc.).

For Questions 7 & 8, ask the patient to use the Patient Rating scale.

7. How troubled or bothered have you been by these medical problems in the past 30 days? [1]
   >Restrict response to problem days of Question 6

8. How important to you now is treatment for these medical problems? [0]
   >Refers to the need for additional medical treatment by the patient.

INTERVIEWER SEVERITY RATING

9. How do you rate the patient's need for medical treatment? [1]
   >Refer to the patient's need for additional medical treatment.

CONFIDENCE RATINGS

Is the above information significantly distorted by:

10. Patient's misrepresentation? 0 - No 1 - Yes [0]

11. Patient's inability to understand? 0 - No 1 - Yes [0]

App. 2/94
E-002-1b

MEDICAL COMMENTS

(Include question number with your notes)

#1 1978- Child birth
1981 & 82- Hysterectomy

#3 Pt. reports having Migraine Headaches

029216
Susan Hearn
DOB: [redacted]
SS#: [redacted]
05/23/95

Tarrant County Mental Health
Mental Retardation Services

029216
Susan Hearn
DOB: [redacted]
SS# [redacted]
05/23/95
(Include Collection Number)

EMPLOYMENT/SUPPORT STATUS

1. Education completed (Years/Months) 08 / 00
   >GED = 12 years, note in comments.
   >Include formal education only. Yrs. Mos.
2. Training or Technical education completed: 00 Mos.
   >Formal/organized training only. For military training, only include training that can be used in civilian life, i.e., electronics vs. artillery.
3. Do you have a profession, trade, or skill? 0-No 1-Yes 1
   >Employable, transferrable skill acquired through training.
   If "Yes" (specify) Cobbing
4. Do you have a valid driver's license? 0-No 1-Yes 0
   >Valid license; not suspended/revoked.
5. Do you have an automobile available? 0-No 1-Yes 0
   >If answer to No. 4 is "No", then No. 5 must be "No". Does not require ownership, only requires availability on a regular basis.
6. How long was your longest full time job? 03 / 00 Yrs. Mos.
   >Full time = 35+ hours weekly; does not necessarily mean most recent job.
7. Usual (or last) occupation? (specify) Beefers Restaurant 4
   (use Hollingshead Categories Reference Sheet)
8. Does someone contribute to your support in anyway? 0-No 1-Yes 0
   >Is patient receiving any regular support (i.e., cash, food, housing) from family/friend. (Include spouse's contribution; exclude support by an institution.
9. Does this constitute the majority of your support? 0-No 1-Yes 0
   >If No. 8 is "No", then No. 9 is "N" for N/A.
10. Usual employment pattern, past three years? 1
    1. Full time (35+ hours) 5. Service
    2. Part time (regular hours) 6. Retired/Disability
    3. Part time (irregular hours) 7. Unemployed
    4. Student 8. In controlled environment
    >Answer should represent the majority of the last 3 years, not just the most recent selection. If there are equal times for more than one category, select that which best represents more current situation.
11. How many days were you paid for working in the past 30 days? 00
    >Include "under the table" work, paid sick days and vacation.

How much money did you receive from the following sources in the past 30 days?

12. Employment?
    >Net or "take home" pay. Include any "under the table" money
13. Unemployment Compensation?
14. Welfare?
    >Include food stamps, transportation money provided by an agency to go to and from treatment.
15. Pensions, benefits or Social Security?
    >Include disability, pensions, retirement, veteran's benefits, SSI & workers' compensation.

App. 2/94
B-002-2

EMPLOYM

#1 Ct. quit school because she got married.

#7 Cts' license is expired

EMPLOYMENT/SUPPORT (cont.)

16. Mate, family, or friends? [0 0 0 0]
>Money for personal expenses, (i.e. clothing), include unreliable sources of income (eg. gambling). Record cash payments only. Include windfalls (unexpected), money from loans, gambling, inheritance, tax returns, etc.)

17. Illegal? [0 0 0 0]
>Cash obtained from drug dealing, stealing, fencing stolen goods, gambling, prostitution, etc. Do not attempt to convert drugs exchanged to a dollar value.

18. How many people depend on you for the majority of their food, shelter, etc.? [0 1]
>Must be regularly depending on patient, do include alimony/child support, do not include the patient or self-supporting spouse, etc.

19. How many days have you experienced employment problems in the past 30 days? [3 0 +]
>Include inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized.

For Questions 20 & 21, ask the patient to use the Patient Rating scale.

20. How troubled or bothered have you been by these employment problems in the past 30 days? [4]
>If the patient has been incarcerated or detained during the past 30 days, they cannot have employment problems. In that case an "N" response is indicated.

21. How important to you now, is counseling for these employment problems? [1]
>The patient's ratings in Questions 20 & 21 refer to Question 19. Stress help in finding or preparing for a job, not giving them a job.

INTERVIEWER SEVERITY RATING

22. How would you rate the patient's need for employment counseling? [4]

CONFIDENCE RATINGS

Is the above information significantly distorted by:

23. Patient's misrepresentation? 0-No 1-Yes [0]

24. Patient's inability to understand? 0-No 1-Yes [0]

029216
Susan Hearn
DOB: [redacted]
SS#: [redacted]
05/23/95

EMPLOYMENT/SUPPORT COMMENTS

(Include question number with your notes)

Client has one 16 year old son, who has been removed from the case by CPS.

Client expresses a desire to get her G.E.D.

Tarrant County Mental Health
Mental Retardation Services

029216
Susan Hearn
DOB: [redacted]
SS# [redacted]
05/23/95

DRUG/ALCOHOL USE

DRUG/AI

Route of Administration Types:
1. Oral 2. Nasal 3. Smoking 4. Non-iv injection 5. IV
Note the usual or most recent route. For more than one route, choose the most severe. The routes are listed from least severe to most severe.

		Past 30 Days	Lifetime	Route of Admin
01	Alcohol (any use at all)	30	27	
02	Alcohol (to intoxication)	30	20	
03	Heroin			
04	Methadone			
05	Other Opiates/Analgesics			
06	Barbiturates			
07	Sedatives/Hypnotics/ Tranquilizers			
	Cocaine (Crack)	24	03	3
09	Amphetamines			
10	Cannabis	30	27	3
11	Hallucinogens			
12	Inhalants			
	More than 1 substance per day (including alcohol)	03	03	

14. According to the interviewer, which substance is the major problem? 16
>Interviewer should determine the major drug of abuse. Code the number next to the drug in questions 01-12. "00" = no problem, "15" = alcohol & one or more drugs, "16" = more than one drug. Ask patient when not clear.

Alcohol/Crack/Cannabis

<OPTIONAL> According to the patient, which substance is the major problem? 16

alcohol/ Crack/ Cannabis

15. How long was your last period of voluntary abstinence from this major substance? 12 Mos.
>Last attempt of at least one month, not necessarily the longest. Periods of hospitalization/incarceration do not count. Periods of anetabuse, methadone, or naltrexone use during abstinence do count. Only show periods 30 days or greater.
00 = never abstinent.

16. How many months ago did this abstinence end? 04 Mos.
>"NN" if question 15 = "00"
>Refers to question 15: "00" = still abstinent.

4 years ago, When Ola Mother died.

17. How many times have you had:
Alcohol DT's? 0
Overdosed on Drugs? 00

Delirium Tremens (DT's) Occur 24-48 hours after last drink, or significant decrease in alcohol intake, shaking, severe disorientation fever, hallucinations, they usually require medical attention.
Overdose (OD) Requires intervention by someone to recover, not simply sleeping it off, include suicide attempts by OD.

App. 2/94
B-002-3

DRUG/ALCOHOL USE (cont.)

18. How many times in your life have you been treated for: Alcohol abuse? 01
    Drug abuse? 01
    >Include detoxification, halfway houses, in/outpatient counseling, and AA or NA (if 3+ meetings within one month period).

19. How many of these were detox only? Alcohol? 00
    Drugs? 00
    >If question 18 = "00", then question 19 = "NN"

20. How much money would you say you spent during the past 30 days on: Alcohol? 0250
    Drugs? 2000
    >Only count actual money spent. What is the financial burden caused by drugs/alcohol?

21. How many days have you been treated as an outpatient for alcohol or drugs in the past 30 days? (include AA/NA) 00

21b. <OPTIONAL> How many days have you been treated as an in-patient for alcohol or drugs in the past 30 days? 00

22. How many days in the past 30 have you experienced: Alcohol problems? 30
    Drug problems? 30
    >Include only: Craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

For questions 23 & 24, ask the patient to use the Patient Rating scale. The Patient is rating the need for additional substance abuse treatment.

23. How troubled or bothered have you been in the past 30 days by these: Alcohol problems? 4
    Drug problems? 4

24. How important to you now is treatment for these: Alcohol problems? 4
    Drug problems? 4

INTERVIEWER RATING

25. How would you rate the patient's need for treatment: Alcohol problems? 7
    Drug problems? 7

CONFIDENCE RATINGS

Is the above information significantly distorted by:

26. Patient's misrepresentation? 0-No 1-Yes 0

27. Patient's inability to understand? 0-No 1-Yes 0

DRUG/ALCOHOL USE COMMENTS

(Include question number with your notes)

Sol. Army TX. Program
(1993) Dallas, Tx
(30-35 days)

Alcohol was bought for Alc.
Cannabis/Crack (were also
bought for Alc. (per Pt.)

029216
Susan Hearn
DOB: [redacted]
SS#: [redacted]

Tarrant County Mental Health
Mental Retardation Services

LEGAL STATUS

LEGAL 029216
Susan Hearn
DOB: [redacted]
SS# [redacted]
05/23/95

1. Was this admission prompted or suggested by the criminal justice system? 0 - No 1 - Yes: 0
   >Judge, probation/parole officer, etc.
2. Are you on parole or probation? 0 - No 1 - Yes: 0
   >Note duration and level in comments.
3. How many times in your life have you been arrested and charged with the following:

03 Shoplift./Vandal.		10 Assault	
04 Parole/Probation		11 Arson	
05 Drug Charges	01	12 Rape	
06 Forgery		13 Homicide/Mansl.	
07 Weapons Offense		14a Prostitution	
08 Burglary/Larceny/B&E		14b Contempt of Court	
09 Robbery		14c Other ___	

   >Include total number of counts, not just convictions. Do not include juvenile (pre-age 18) crimes, unless they were charged as an adult. Include formal charges only.
15. How many of these charges resulted in convictions? 01
    >If 03-14 = "00", then question 15 = "NN".
    >Do not include misdemeanor offenses in questions 16-18 below.
    >Convictions include fines, probation, incarcerations, suspended sentences, and guilty pleas.

How many times in your life have you been charged with the following:

16. Disorderly conduct, vagrancy, public intoxication? 01
17. Driving while intoxicated? 00
18. Major driving violations? 01
    >Moving violations: speeding, reckless driving, no license, etc.
19. How many months were you incarcerated in your life? ___ Mos.
    >If incarcerated 2 weeks or more, round this up to 1 month. List total number of months incarcerated.
20. How long was your last incarceration? ___ Mos.
    >Enter "NN" if never incarcerated.
21. What was it for? 05
    >Use code 03-14, 16-18. If multiple charges, use most severe code. Enter "NN" if never incarcerated.
22. Are you presently awaiting charges, trial, or sentence? 0 - No 1 - Yes: 0
23. What for? 00
    >Refers to Q# 22. If more than one, choose most severe. Don't include civil cases, unless a criminal offense is involved.

How many days in the past 30, were you detained or incarcerated? 00
>Include being arrested and released on the same day.

5 days

5 days

and #16

App. 2/94
8-002-4

LEGAL STATUS (cont.)

25. How many days in the past 30, have you engaged in illegal activities for profit? [0 0]
> Exclude simple drug possession. Include drug dealing, prostitution, selling stolen goods, etc. May be cross checked with Question 17 under Employment/Family Support Section.

For questions 26 & 27, ask the patient to use the Patient Rating scale.

26. How serious do you feel your present legal problems are? > exclude civil problems [3]

27. How important to you now is counseling or referral for these legal problems? [1]
> Patient is rating a need for additional referral to legal counsel for defense against criminal charges.

INTERVIEWER SEVERITY RATING

28. How would you rate the patient's need for legal services or counseling? [3]

CONFIDENCE RATINGS

Is the above information significantly distorted by:

29. Patient's misrepresentation? 0 - No 1 - Yes [0]

30. Patient's inability to understand? 0 - No 1 - Yes [0]

LEGAL COMMENTS

(Include question number with your notes)

Clt' 16 yr. old son Ray Leon removed from Clt' care through CPS.

029216
Susan Hearn
DOB: [redacted]
SS#: [redacted]
05/23/95

FAMILY HISTORY

Have any of your blood-related relatives ever had what you would call a significant drinking, drug use, or psychiatric problem. One that did or should have led to treatment?

Mother's Side	Alcohol	Drug	Psych.	Father's Side	Alcohol	Drug	Psych.	Siblings	Alcohol	Drug	Psych.
Grandmother	0	0	0	Grandmother	0	0	1	Brother 1	N	N	N
Grandfather	0	0	0	Grandfather	X	X	X	Brother 2	N	N	N
Mother	0	0	0	Father	1	0	0	Sister 1 (Step)	N	N	N
Aunt (1)	1	0	0	Aunt (6)	1	0	X	Sister 2	1	1	0
Uncle (4)	1	0	0	Uncle (1)	1	0	X	" 2 (Natural)	1	1	0
									0	0	0

0 = Clearly No for all relatives in that category
1 = Clearly Yes for all relatives in that category
X = Uncertain or don't know
N = Never was a relative

> In cases where there is more than one person for a category, report the most severe. Accept the patient's judgement on these questions.

FAMILY HISTORY COMMENTS

Clt' is the "Baby" in her family. Clt's parents are deceased. Clt's father died in 1985 (Cancer). Clt's Mother died in 1991 (Natural Causes)

Tarrant County Mental Health
Mental Retardation Services

029216
Susan Hearn
DOB: [redacted]
SS#: [redacted]
05/23/95

FAMILY/SOCIAL RELATIONSHIPS

FAMILY/SOC

1. Marital Status [4]
   1-Married 3-Widowed 4-Divorced
   2-Remarried 4-Separated 5-Never Married
   >Common-law marriage = "1". Specify in comments.

2. How long have you been in this marital status (Q #1)? [1][9] / [0][0] Yrs. Mos.
   >If never married, then since age 18.

3. Are you satisfied with this situation? 0-No 1-Indifferent 2-Yes [2]
   >Satisfied = generally liking the situation.
   Refers to Questions 1 & 2.

4. Usual living arrangements (past 3 years): [5]
   1-With sexual partner & children 6-With friends
   2-With sexual partner alone 7-Alone
   3-With children alone 8-Controlled Environ.
   4-With parents 9-No stable arrangement
   5-With family
   >Choose arrangements most representative of the past 3 years. If there is an even split in time between these arrangements, choose the most recent arrangement.

5. How long have you lived in these arrangements? [0][2] / [0][0] Yrs. Mos.
   >If with parents or family, since age 18.
   >Code years and months living in arrangements from Question 4.

6. Are you satisfied with these arrangements? 0-No 1-Indifferent 2-Yes [0]
   >If with parents or family, since age 18.
   >Code years and months living in arrangements from Question 4.

Do you live with anyone who:

6a. Has a current alcohol problem? 0-No 1-Yes [1]

6b. Uses non-prescribed drugs? 0-No 1-Yes [1]

7. With whom do you spend most of your free time? 1-Family 2-Friends 3-Alone [2]
   >If a girlfriend/boyfriend is considered as a family by patient, then they must refer to them as family throughout this section, not a friend. Family is not to be referred to as "friend".

8. Are you satisfied with spending your free time this way? 0-No 1-Indifferent 2-Yes [1]
   >A satisfied response must indicate that the person generally likes the situation. Referring to Question 7.

9. How many close friends do you have? [0]
   >Stress that you mean close. Exclude family members. These are "reciprocal" relationships or mutually supportive relationships.

9A. Would you say you have had a close reciprocal relationship with any of the following people:

Mother	[1]	Sexual Partner/Spouse	[1]
Father	[1]	Children	[1]
Brothers/Sisters	[0]	Friends	[N]

0=Clearly No for all in class. X=Uncertain or Unknown,
1=Clearly Yes for any in class. N=Never was a relative.

>By reciprocal, you mean "that you would do anything you could to help them out and vice versa".

(Include question number with your notes)

Pt. is separated from her husband. Pt's 16 yr. old son was by another man, who is now deceased.

Pt. was living w her sister prior to going to the PWS (right shelter)

Pt. reports she has no close friends because she doesn't trust easily.

App. 1/94
8-002-5

FAMILY/SOCIAL (cont.)

Have you had significant periods in which you have experienced serious problems getting along with:

	0 - No 1 - Yes Past 30 days	In Your Life
10. Mother	0	0
11. Father	0	0
12. Brother/Sisters	1	1
13. Sexual Partner/Spouse	0	1
14. Children	1	1
15. Other Significant Family (specify)_____	0	0
16. Close Friends	0	0
17. Neighbors (people at shelter)	1	1
18. Co-workers	0	0

"Serious problems" mean those that endangered the relationship. A "problem" requires contact of some sort, either by telephone or in person.

Did any of these people (Question 10 - 18) abuse you?

	0 - No 1 - Yes Past 30 days	In Your Life
18a. Emotionally? >Made you feel bad through harsh words.	1	1
18b. Physically? >Caused you physical harm.	0	1
18c. Sexually? >Forced sexual advances/acts.	0	1

How many days in the past 30 have you had serious conflicts:

19a. With your family?	10
19b. With other people (excluding family)?	03

For Questions 20-23, ask the patient to use the Patient Rating scale.
How troubled or bothered have you been in the past 30 days by:

20. Family problems	4
21. Social problems	3

How important to you now is treatment or counseling for these:

22. Family problems >Patient is rating his family's need for counseling for family problems, not whether they would be willing to attend.	4
23. Social problems >Exclude patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Patient rating should refer to dissatisfaction; conflicts, or other serious problems. Exclude problems that would be eliminated if patient had no substance abuse.	2

INTERVIEWER SEVERITY RATING

24. How would you rate the patient's need for family and/or social counseling?	6

CONFIDENCE RATING

Is the above information significantly distorted by:

25. Patient's misrepresentation?	0-No 1-Yes	0
26. Patient's inability to understand?	0-No 1-Yes	0

App. 2/94
E-002-5b

FAMILY/SOCIAL COMMENTS

(Include question number with your notes)

029216
Susan Hearn
DOB: [redacted]
SS#: [redacted]
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18A. Family - Pt's father was alcoholic (shame, fear, grief in home)
18B- Parents - beatings
18C- Pt was raped by 3 men 4yrs. ago. Pt never received any help or support.

Pt. shared that her sisters were abusive to her through out her childhood. Pt. reports they once locked her in a dark closet a rats for hours. They put her in a bathtub of extremely hot water and burned her badly. One sister pushed her into a hot stove burning pt's [illegible] arm. Pt. showed Caseworker scars from this burn. Pt. has alot of resentment for her sisters.

Tarrant County Mental Health
Mental Retardation Services

029216
Susan Hearn
DOB: [redacted]
SS#: [redacted]
05/23/95

PSYCHOLOGICAL STATUS

1. How many times have you been treated for any psychological or emotional problems:
   In a Hospital or inpatient setting? 03
   Outpatient/private patient? 00
   > Do not include substance abuse, employment, or family counseling. Treatment episode = a series of more or less continuous visits or treatment days, not the number of visits or treatment days.
   > Enter diagnosis in comments if known.

2. Do you receive a pension for a psychiatric disability? 0-No 1-Yes 0

Have you had a significant period of time (that was not a direct result of alcohol/drug use) in which you have:

	0-No 1-Yes	Past 30 Days	Lifetime
3.	Experienced serious depression-sadness, hopelessness, loss of interest, difficulty with daily function?	1	1
4.	Experienced serious anxiety/tension-uptight, unreasonably worried, inability to feel relaxed?	1	1
5.	Experienced hallucinations-saw things or heard voices that were not there?	0	0
6.	Experienced trouble understanding, concentrating, or remembering?	0	0
7.	Experienced trouble controlling violent behavior including episodes of rage, or violence? > Patient can be under the influence of alcohol/drugs.	0	1
8.	Experienced serious thoughts of suicide? > Patient seriously considered a plan for taking his/her life.	0	1
9.	Attempted suicide? > Include actual suicidal gestures or attempts.	0	3
10.	Been prescribed medication for any psychological or emotional problems? > Prescribed for the patient by MD. Record "Yes" if a medication was prescribed even if the patient is not taking it.	0	1

11. How many days in the past 30 have you experienced these psychological or emotional problems? 20
    > This refers to problems noted in Questions 3-9.

For Question 12-13, ask the patient to use the Patient Rating scale.

12. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? 4
    > Patient should be rating the problem days from Question 11.

13. How important to you now is treatment for these psychological or emotional problems? 4

App. 2/94
E-002-6

PSYCHOLOGIC

(Include ques...

Parkland Psych. ER
Dallas, Texas
Ct. stated that Lee mother took Lee to Parkland because she attempted suicide - drinking and took pills. Ct. reports she believes she has "emotional problems". Ct. reports Lee problems are: (1) Drug/alcohol use (2) Grieving parents deaths (3) anger towards Lee sisters, (4) Being raped 4 yrs. ago, (5) problems with Lee 16 yr. old son.
When drinking ct. has been aggressive. Also, ct. has "gone off" on Lee sisters before.

Valium) - Parkland Hosp. doctor (two others unknown meds. for nerves/anxiety)

PSYCHOLOGICAL STATUS (cont.)

The following items are to be completed by the interviewer:

At the time of the interview, the patient was: (0-No 1-Yes)

14. Obviously depressed/withdrawn [0]
15. Obviously hostile [0]
16. Obviously anxious/nervous [1]
17. Having trouble with reality testing, thought disorders, paranoid thinking [0]
18. Having trouble comprehending, concentrating, remembering [0]
19. Having suicidal thoughts [0]

INTERVIEWER SEVERITY RATING

20. How would you rate the patient's need for psychiatric/psychological treatment? [6]

CONFIDENCE RATING

21. Patient's misrepresentation? (0-No 1-Yes) [0]
22. Patient's inability to understand? (0-No 1-Yes) [0]

Date: 5-31-95

Carolyn Cates LCDC

Signature Title

Unit #: 250

029216
Susan Hearn
DOB: [redacted]
SS#: [redacted]
05/23/95

PSYCHOLOGICAL STATUS COMMENTS

(Include question number with your notes)

App. 2/94
B-002-6b

TARRANT COUNTY MHMRS
Alcohol Services

029216
Susan Hearn
CLIENT NUI DOB: [redacted]
CLIENT NAI SS#: [redacted]
ADMISSION 05/23/95

INITIAL INPATIENT ASSESSMENT

How did you hear about this program? CPS
What is your address 2400 Evans Tel.# none
Have you ever been in a Texas state hospital? no

I. VITAL STATISTICS
Sex F Race B D.O.B. [redacted] Marital Status Sep.
34 Weight 120 B.P. 131/85 Pulse 80 Temp 98 Resp. 12

II. PERSONAL MEDICAL HISTORY

	Yes	No	Dates	Elaboration
High B.P.		✓		
Diabetes		✓		
Heart Disease		✓		
Glaucoma		✓		
Tuberculosis		✓		
Liver Disease		✓		

Have you ever had D.T.'s no
Have you ever had seizures or convulsions no explain
Describe any gastrointestinal problems nervous stomach
Other illnesses or surgeries migraine HA since age 15 takes Tylenol
Psychiatric History depression & anxiety - seen @ Harris & Parkland - doesn't take meds
Accidents and injuries (explain) no
List all Medicines taken within the past six months:
Antibiotics
ALLERGIES: Penicillin Other NKA

III. FAMILY MEDICAL HISTORY

	Yes	No	Family Member
Alcoholism	✓		father
High B.P.	✓		father
Diabetes	✓		mom
Heart Disease	✓		mom
Glaucoma		✓	
Other Cancer	✓		father

IV. NURSES IMPRESSIONS

General Health fair Sclera Jaundiced none
Lacerations no Describe
Intoxicated no Withdrawal Symptoms none
Grooming fair Attitude co-op Cognition oriented x 3
Comments

Rev. 5-84
E-102-1

029216
Susan Hearn
DOB: [redacted]
SS#: [redacted]
05/23/95

V. SUBSTANCE ABUSE

A. Alcohol Abuse

IN THE PAST 30 DAYS HOW MANY DAYS DID YOU DRINK:

Beer? 30 No. of quarts: ____ No. cans/bottles: 3-4-4/012
Wine? 3-4 No. of fifths: ____ No. of glasses 8 oz GLASS
Hard liquor? 0 No. pints: ____ No. shots/drinks ____
When was your last drink? 5-22-95

Have you experienced the following?

	Yes	No	Comments
Memory lapses/blackouts	✓		
Shakes/tremors		✓	
Drink upon waking		✓	
Miss meals due to drinking		✓	
Miss work or daily activities	✓		
Drinking on the job		✓	
Fight or quarrel with others	✓		
Illnesses due to drinking		✓	
DWI arrests	✓		
Drunk in public arrests	✓		1 MONTH AGO

No. of previous admissions at ARC 0 Dates ____
List other treatments for alcoholism and dates: 1992 - DALLAS SALVATION ARMY

How would you describe your drinking behavior (circle one)

No problem Slight problem Moderate problem (Severe problem)

B. Other Drug Abuse - Check the drug(s) you have ever used:

		Age Began	Last used	How Much
✓	Marijuana	10	5-21-95	
	Hashish			
	LSD			
✓	Amphetamines (speed)	15	1986	
✓	Cocaine	30	5-21-95	
	Barbiturates (downers)			
	Methaqualone (quaalude)			
	Codeine			
	Cough Syrup			
	Illicit Methadone			
	Heroin			
	Dilaudid, Demerol			
	Valium, Librium			
	Darvon, Darvocet			
	Solvents, glue, paints, etc.			
	Other: Specify			

What is your drug of choice? MARIJUANA (PRIMO)

Signature/title

E-102-1b

TARRANT COUNTY MHMR
ALCOHOL SERVICES INPATIENT

CLIENT NUM 029216
CLIENT NAME Susan Hearn
SS# [redacted]
ADMISSION DATE 05/23/95

VI. EDUCATIONAL BACKGROUND

A. (Circle One) Highest Grade Completed:

1 2 3 4 5 6 7 (8) 9 10 11 12 (GED) 13 14 15 16 17 18

B. Relationship with teachers and other students: LOVER

C. Circumstances surrounding dropping out of school: "JUST QUIT" Preg.

D. Degrees earned:

E. Licensures, Certificates, and/or Technical Training CREW CHIEF FOR FOOD SERVICES.

VII. FAMILY RELATIONSHIPS

A. How long have you lived in this area? 2yrs.
B. Where were you born? MCKINNEY, TX
C. Are your parents living? NO Where?
D. How many brothers, sisters do you have? 3 SIS
E. How do you remember your relationship with mother, father, siblings? (F) GOOD (M) GOOD/SIBLINGS - DIDN'T GET ALONG/CT YOUNGEST
F. Are you a veteran? NO When in service?
G. Have you ever been in (jail) ~~prison~~? For what charges? P.I.
H. What type of residence have you been living in?(circle one).

Private residence (house, apt., etc)

Boarding house (dormitory, mission, etc.)

Jail or prison Hospital Halfway house

Nursing home Motel room (Have no place)

I. What kind of family support do you currently have available? NO

J. What is your current relationship with family members? NONE

5-23-95
Date

Donna L-C
Signature/Title

Rev. 5-84
E-102-2

EXHIBIT 6

154a13

HEARN, YOKAMON L.

[redacted]

CONFIDENTIAL

FOR PROFESSIONAL USE ONLY

1154125

PHOTOCOPY

CONSENT FOR RELEASE OF INFORMATION

(SPANISH LANGUAGE OTHER SIDE)

CHART NUMBER

PARKLAND MEMORIAL HOSPITAL
DALLAS COUNTY HOSPITAL DISTRICT
5201 HARRY HINES BLVD.
DALLAS, TEXAS 75232

Client or Legal Representative

hereby authorize:

DALLAS COUNTY MENTAL HEALTH/MENTAL RETARDATION
OUT-PATIENT CLINICS, GRADY NIELO, MEDICAL DIR.
CICI MENTAL HEALTH CLINIC
DALLAS, TEXAS

to disclose records and/or information concerning Jokanion L. Hearn to:

The disclosure of information authorized herein

is made for the following purpose: CONTINUING MEDICAL/PSYCHIATRIC OUT-PATIENT TREATMENT

and such disclosure shall be limited to the following specific types of information: MEDICAL/PSYCHIATRIC EVALUATION AND TREATMENT

This client received services in your facility in January of 1989.

1-10-89 Susan D. Hearn

Date of Signature Client or Legal Representative

Client's Date of Birth Relationship of Legal Representative

This consent may be revoked by the person giving authorization by signing and dating the revocation statement below or through written notice except to the extent that action has been taken in reliance hereon. If not earlier revoked, this consent shall terminate on _____ without express revocation.

Date, Event, or Condition

On this day _____ of 19____, I revoke this consent:

ADMINISTRATIVE OFFICES
1341 W. Mockingbird Ln
Suite 1000-E
Dallas, Texas 75247
(214) 637-4600
Central Intake/Crisis Intervention
1353 N. Westmoreland Avenue, Bldg. A
Dallas, Texas 75211-1655
(214) 337-6074

dallas county Mental Health and Mental Retardation center

PSYCHIATRIC EVALUATION

CLIENT'S NAME:	Hearn, Yokamon
DATE OF BIRTH:	[redacted]
DATE OF EVALUATION:	01-16-89
CHART NUMBER:	154215
EXAMINER:	Marietta Chua, M.D. Child Psychiatrist

REASON FOR REFERRAL

This is a ten year old black boy who was referred by PMH ER for an evaluation for follow-up concerning suicidal ideations.

HISTORY OF PRESENTING PROBLEM

Mother saw a note that Yokamon wrote four days ago. The note stated "I wish to die tonight, I never want to see the world again". It was said that Yokamon wrote it after he heard his teacher is leaving. Mother claimed that before Christmas, Yokamon's attitude changed. If asked to do something, he would be angry and stump his feet. Mother claimed he used to be open with her but not now. Mother claimed there has been several de-ths in the family. When maternal grandfather died in 1985, mother used to go to Parkland for anxiety fora year. She was taking Doxepin 25 mg 4-5 tablets H.S. Mother claimed that Yokamon's father was a drug abuser. Yokamon gets A's and B's in school.

For more information refer to the screening data.

MENTAL STATUS

He is a chubyy, average height boy who was appropriately groomed. He often covers his mouth or holds his lips when he sort of stammers. He was verbal and spontaneous. He had good eye contact. Affect was appropriate; mood was mildly despondent. He claimed

PSYCHIATRIC EVALUATION
Hearn, Yokamon P-2

MENTAL STATUS (con't) he is both sad and angry. He claimed that what makes him angry is when mother buys picture of somebody being killed. He claimed he gets sad when his cousin gets beat up. He claimed when he was in second grade he beat up . boy. He claimed that his mother moved him to another school in January 1989 because mother didn't like the school where he used to go because kids beat up other kids. Since January, he claimed he has nightmares of people jumping out of airplanes and trying to kill him. He claimed he don't like going to school even though he gets A's and B's in school. He would like to be a policeman to get more money. He described his mother as a nice person. Three things he would like to have are: 1. education
2. diploma
3. to have life

He claimed he saw ghost in the wall but disappeared after he closed his eyes. No hallucinations. He claimed that death is bad thing to happen. He claimed that he one can come back again even if they die because his kother told him that what ever God takes from earth can return to earth. Oriented x 3. No soft signs of neurological deficit. He had difficulty reading but comprehension seems good. TAT indicates some sadness. He claimed he wrote the note four days ago. He claimed he wrote the note because he felt bad but didn't know why. He didn't have plans how to kill self. He claimed he don't want to die at this point because he was told that people who kill themselves does not go to heaven. He also don't want to leave his mother. Not suicidal and not homicidal.

DIAGNOSIS

AXIS I. Adjustment disorder with depressed mood- 309.00

AXIS II. Diagnosis deferred- 799.90

AXIS III. None

AXIS IV. 4- severe

AXIS V. 50- current (GAF)
70- past (GAF)

TREATMENT

Refer to outpatient for individual therapy.

MC/mjs

Marletta Chua, M.D.
Child Psychiatrist

CASE MANAGEMENT ASSESSMENT/REFERRAL FORM

CLIENT NAME: Hearn Ukeamm CASE NO.: 154215

Check all of the following which apply. Case Management staff will use this form to determine eligibility for Case Management Services, and to prioritize this case for receiving Case Management Services if the client is eligible. If, upon completion of the form, the client appears eligible for Case Management Services, send a copy of this form, the Screening Interview, and any relevant Assessment forms, to the Case Management Supervisor. Place the original of this form in the client's chart.

____ The client is being transferred to, or is returning from, a psychiatric inpatient facility.

____ The client is being transferred, or is at substantial risk of being transferred, from a less restrictive to a more restrictive mode of treatment (i.e., from Outpatient Services to Day Treatment Services, or from Day Treatment Services to Inpatient Services—this does not include transfers from the Community into Outpatient Treatment).

____ There is an absence of, or a major breakdown in, a primary support system. Specify one or more of the following:

____ Basic life support needs of the family are met as a result of linkages with community support services such as family social services, SSI, or medication, and there is a need for advocacy (other than simple referral and linking) with one or more of these support services.

____ The client's family requires public financial assistance for maintenance, and is unable to procure financial assistance without help.

____ The client's family is unemployed and has limited skills in acquiring and/or maintaining employment.

____ Other (Specify:_____

_____

____ The client or the client's family exhibits inappropriate social behavior which has resulted in a demand for intervention by the mental health and/or the law enforcement/judicial system.

If any item above is checked, provide details: Client is not in need of Case management Services at this time.

CASE MANAGEMENT USE ONLY

Based on referral information, indicate the level of need assigned to this referral:

____ Priority 1 ____ Priority 2 ____ Priority 3

_____ Initials of Case Management Supervisor

Place the original of this form in the client's chart.

Staff signature: Margie Mejo BSW Date: 1-16-89

SCREENING INTERVIEW

SECTION A: The information in this section is to be completed separately for each member of the family who is admitted for services.

CLIENT NAME: Yokamon Hearn CASE NO.: 154215

INFORMANT NAME: Susan Hearn DATE: 1-16-89

RELATIONSHIP TO CLIENT: mother

MANAGING CONSERVATOR (Name and address):

PROOF OF CUSTODY: ____ Yes ____ No (Provide photocopy if required for admission)

HAS FORM 2054 COMPLETED: ____ Yes ____ N/A (Attach 2054 if required for admission)

REFERRAL SOURCE:

NATURE OF CRIMINAL OR CIVIL COURT, OR CHILD WELFARE INVOLVEMENT (Include name and address of case-worker, probation officer, etc., if applicable):

PROBLEM CHECKLIST:

DANGER TO SELF
- ✓ Suicidal Note
- __ Self-destructive
- __ Puts self in life-threatening situations
- __ Anorexic/Bulemic

DANGER TO OTHERS
- __ Violent to Persons
- __ Sexually Violent
- __ Abusive Caretaker
- __ Neglecting Parent
- __ Fire Setting

IN DANGER
- __ Family Violence
- __ Physically Abused
- __ Sexually Abused
- __ Neglected
- __ Dangerous Home Environment
- __ Abandoned/Kicked Out Of Home

OTHER PSYCHIATRIC DISORDER
- __ Kills/Tortures Animals
- __ Major Depression
- __ Autistic Behavior
- __ Bizarre Behavior
- __ Thought Disorder
- __ Drug/Alcohol Abuse
- __ MR/ED
- __ School Expulsion
- __ Sexual Acting Out
- __ Chronic Runaway

OTHER DISTURBANCE (Specify):

BRIEF MENTAL STATUS EXAMINATION (Include a brief Mental Status Examination on any family member for whom it seems appropriate—e.g., if there is apparent thought disorder, danger to self or others, etc.).

AT THE END OF THE INTERVIEW, DID THE CLIENT

Feel like they had been heard and understood? ✓ Yes __ No*

Understand what would happen next? ✓ Yes __ No*

Have realistic expectations of what assistance we could provide? ✓ Yes __ No*

* If any answer is no, please elaborate in "Interviewer's Impressions" Section of this form.

SECTION B: The information in this section is to be completed for the family as a whole, and a copy will be placed in each family member's chart. Any client identifying information in this section must comply with the CBA Services Procedures for making chart entries.

PRESENTING PROBLEM (Cover all areas outlined below):

__ What does the informant see as the problem?
__ What does the informant think is causing the problem?
__ Duration of the problem?
__ Why is help being sought now?
__ What does the informant want us to do?

Susan Nixon, ma to Yokamon stated that she did not know what the problem is with her son. She stated that she notice her sons behavior change right before Christmas. Susan never married Yokamon's fa. When she was pregnant with Y., YS fa. served time in prison for raping a woman. After he was released from prison, Susan had limited contact with him. However, he would keep Yokamon on some week-ends. Susan stopped the visits when she found out fa was sleeping in a car. She described him as a violent man who uses drugs. Yokamon has seen his fa. on fa's day, & on fa's birthday.

Susan's fa died in 1995 and she stated she has never dealt with her own fa's death. Susan used to drink a lot of liquor but now she drinks beer occasionally. She at times becomes depressed & cries. Yokamon, according to Susan senses when ma is depressed & will go into her room to check on her, stating he was just going to the bathroom. Help is being sought now due to a note he wrote in school stating he wishes he would die. School teacher & counselor became concerned & referred Y. & his ma to PMH. Susan would like someone to talk to Y. to find out how he really is feeling, since he no longer opens up to her.

FAMILY CONSTELLATION (List the names and ages of others who live in the home, the names and ages of other family members who may not live in the home, and other relevant information about extended family members or other important support systems. Indicate which family members need to be involved in the assessment):

Y.P. Yokamon 10, lives with his Natural M.O. Susan 28, and his maternal grandma Willie Mae Ross 56.
paternal grandfa. died of Cancer in 1985 - Yokamon repeated the first grade at this time due to not turning like doing his WK. May have been depressed due to grandfa's death.

RECENT HISTORY (What major changes or events have occured recently--e.g., deaths, school changes, people coming to/going from home, family or relatives moving, etc.):

No major changes have occured recently, according to mo. Only change she notices is that he became angry & sad when his fa. gave Y. some used toys on his birthday 11-6-85.

TREATMENT HISTORY (List current or previous treatment of any family members. Include information about medications being taken by any family members, and the name and address of the prescribing physician):

No treatment for Yokamon.
Susan was being seen at PMH for anxiety. This was right after her fa's death in 1985. She discontinued her treatment 1 yr. ago, but still has some of her medication left which she states to take when she becomes anxious. Medication is: Doxepin 25mg. 4-5 tablets at bedtime.

INTERVIEWER IMPRESSIONS (Outline your impressions from the interview. In addition, outline here your recommended disposition of the case--including the urgency of needed intervention and the form this might take):

Yokamon Nearn is a 10 yr old black male who was referred by PMH. Yokamon had written a note stating he wanted to die. Yokamon seems to be very angry at fa. who rarely visits him and gave his used toys for his birthday. He seems to be aware when mo. is feeling depressed which seems to saddend him. Mo. stated that she use to sit down with Yokamon & talks to him like an adult. This may be stressful for Yokamon who may feel helpless. It seems that mo's depression and/or anxiety may be affecting Yokamon.
Yokamon could benefit from individual therapy to help cope with feelings of sadness & anger. Mo. could also benefit from individual to help cope with his fa's death, and learn effective ways to be a parent to Yokamon. It seems that she has difficulty separating from Yokamon for fear that she will loose him also, like she did her dad.

ELIGIBILITY FOR C&A SERVICES: Check all of the following which apply. One or more categories must be checked for an applicant to be eligible for C&A Mental Health Services.

- ✓ The child or adolescent and/or his/her family live in Dallas County.
- ___ The family includes a child or adolescent with a history of psychiatric inpatient care.
- ___ The family includes a child or adolescent and is experiencing a psychiatric emergency.
- ___ The family includes a child or adolescent and has a parent or other adult living in the home who has a history of psychiatric inpatient care.
- ___ According to your clinical judgment, the child or adolescent is at serious risk of needing psychiatric inpatient care.

CLIENT ACCESS TO SERVICES (Describe any factors that might affect the time of appointments or the ability of the client to come in for appointments—e.g., working hours, transportation, motivation, etc. Indicate the language preference of relevant family members, and any deficits or limitations in communication ability):

Mo. seems motivated to receive therapy for Yokamon + herself. She works during the day, while Yokamon attends school. She may need an evening appt.

CONTINUITY OF SERVICES (Indicate the date, time, and place of the next appointment secured for the family, whether with an MHMR unit or another agency. Include the name of the staff member who has been identified to the family as having responsibility for their treatment at the receiving service location):

Yokamon has an appt. at Centie St. with Debra Coates on 1-26-89 at 1:30 p.m.

CASE COORDINATION RESPONSIBILITY:

I have informed the client that I will serve as their Case Coordinator until that responsibility is formally transferred to someone else. ✓ Yes ___ No

I have explained to the client the responsibilities involved in being the Case Coodinator. ✓ Yes ___ No

SCREENING FOR STATE FACILITY ADMISSION: (To be completed only if the client is being considered for admission to a state facility):

The referral of this client to a state facility is based on the determination of the presence of a disability appropriate for treatment in a state facility. ___ Yes ___ No

I have determined there are no less restrictive community-based alternatives which are appropriate for the treatment of this client. ___ Yes ___ No

Maiya Tezeño

ASSESSMENT FORM

CLIENT NAME: Yokomon Hearn CASE NO.: 154215

SECTION A: This form, a Mental Status Exam (if not previously completed), and a Developmental History (if the client is a child) are to be completed for each client admitted to services. The Assessment Form in its entirety (Sections A and B) must be completed within 30 days of the date of admission.

EDUCATIONAL HISTORY (For children and youth, provide name of school, grade level attained, and school attendance history. For adults, provide highest grade level attained, plus any special training completed):

Yokomon attends B.F. Darrell Elementary School. He is in the third grade. He has been there for two years.

HEALTH STATUS (Include physical limitations, use of prescription and non-prescription medications taken currently and during the past six months—including alcohol and illicit drugs—and allergies and sensitivities):

Yokomon does not have any health problems. He hasn't been bothered with the asthma for 6-7 years. He does not take any medications.

DIAGNOSTIC FORMULATION (Provide a diagnostic formulation, based on the clinical evidence available, which supports the formulation on all five DSM-III axes):

A1 Adjustment disorder with depressed mood 309.00

A2 Diagnosis deferred 799.90

A3 None

A4 severe

A5 50 current 70 past

STAFF SIGNATURE: Debra Cortez/SWACP DATE: 1/26/89

SECTION B: The information in this setion is to be completed for the family as a whole, and a copy will be placed in each family member's chart. Any client identifying information in this section must comply with the C&A Services Procedures for making chart entires.

SOCIAL ASSESSMENT (Cover all areas outlined below):

____ A social assessment that includes a statement of the client's strengths and other resources which may contribute to the course of treatment.

____ A summary of input from client, family, and/or parent/legal guardian, friends, or significant others.

____ Summaries of input from pertinent service agents with whom the client is or has been involved.

Yohamon is very verbal. He comprehends well. He played throughout the interview and answered questions readily. Yohamon says he does not see his mother when she is unhappy or is crying because she goes in her room. He has learned similarly to keep his feelings to himself. He also says he does not know how he feels about his father. Yohamon states he does not want to die. He has experienced the death of his grandfather.

STAFF SIGNATURE: [illegible], LSW-ACP DATE: 1/26/89

DEVELOPMENTAL HISTORY

CLIENT NAME: Yokanon Hearn CASE NO.: 00154215

A Developmental History is to be completed on each child or adolescent admitted for services. The Developmental History is to be administered as an interview with the person who is most familiar with the child's development. For each item below, fill in the requested information, or check whether the item is significant to the child's development. For any item that is significant, enter additional information in the space provided.

		No	Yes	Explain
A.	DURING PREGNANCY:			
1.	Mother's age: 18			
2.	Term of pregnancy: 9 mos			
3.	Did Mother have emotional problems?	___	✓	father in prison
4.	Did Father have emotional problems?	___	___	never saw him
5.	Did Mother have physical problems or sickness?	___	✓	low blood; nervous condition
6.	Did Mother use drugs, alcohol, or use cigarettes?	___	✓	smoked cigarettes; drank beer
7.	Did Mother take medicine (prescribed, or over the counter?)	✓	___	
B.	DURING LABOR OR DELIVERY:			
1.	What was birth weight? 7lbs 6oz			
2.	What was birth length? ___			doesn't remember
3.	Were there problems with labor?	✓	___	
4.	Were there problems with delivery (e.g., forceps or caesarean)?	✓	___	
5.	Was anethesia used?	___	✓	
6.	Condition of baby at birth abnormal or problematic?	✓	___	
7.	Condition of baby in first six months abnormal or problematic?	___	✓	developed asthma at 5 months
8.	Did Mother have emotional or physical problems?	___	✓	grandmother died

C. DURING INFANCY AND BEYOND:

		No	Yes	Explain
1.	Was baby breast fed?	✓		
2.	Did mother have help with care of baby?		✓	
3.	Were there problems meeting developmental milestones?	✓		
4.	At what age did the baby:			
	sit alone?	8 months		
	begin talking?	1 yr		
	walk?	1 yr		
	feed self?	1½ yrs		
	put on shoes?	2 yrs		
	complete toilet training?	1 yr		
5.	For girls:			
	age of breast growth			
	age of first period			
	are there problems before or during menstruation?			
6.	For boys:			
	age of pubic hair growth			
	age of voice change			

D. SUMMARY OF SIGNIFICANT FACTORS:

mother says she has always been a nervous person. She says she holds everything in.

STAFF SIGNATURE: Debra G. Fox, CSW/ACP DATE: 1/26/89

dallas county Mental Health and Mental Retardation center

TRANSFER/DISCHARGE SUMMARY

PAGE 1

LaKamon Hearn	10	1-16-89	C/I
CLIENT NAME	AGE	ADMISSION DATE	O. P. NAME
154215	M	1-26-89	Margie Trejo
CASE NUMBER	SEX	CLOSING DATE	CASE MANAGER

ACTION: ☑ TRANSFER WITHIN AGENCY (COMPLETE PAGE 1 ONLY) → Centre St. (UNIT REFERRED TO)

☐ DISCHARGE FROM AGENCY (COMPLETE PAGES 1 & 2) → 1-26-89, 1:30 p.m. (APPOINTMENT DATE AND TIME)

FOR TRANSFERS AND DISCHARGES, ADDRESS THE FOLLOWING SIX ITEMS:

1. REASON FOR ADMISSION
2. PRESCRIBED MEDICATIONS AT TIME OF TRANSFER/DISCHARGE
3. RECOMMENDATIONS FOR FUTURE TREATMENT (TRANSFERS ONLY)

1. Wrists Suicidal Note, School Concerned

2. none

3. Individual and family therapy

4. REASON FOR TRANSFER/DISCHARGE: ☑ MAXIMUM BENEFIT ACHIEVED ☐ CLIENT WITHDREW ☐ MOVED ☐ DIED ☐ OTHER (SPECIFY)

WAS THIS AGAINST PROFESSIONAL ADVICE? ☐ YES ☐ NO

5. DIAGNOSIS: DSM-III

		CODE
AXIS I	Adjustment D.O. w/Depressed Mood	309.00
AXIS II	Depressed	799.90
AXIS III	None	

AXIS IV: 4 (1 NONE, 2 MILD, 3 MODERATE, 4 SEVERE, 5 EXTREME, 6 CATASTROPHIC, 7 INADEQUATE/NO)

AXIS V-GLOBAL ASSESSMENT OF FUNCTIONING: CURRENT 50, PAST YEAR 70

6. ALLERGIES: Unknown

Margie Trejo BSW — Caseworker III — 1-20-89

SIGNATURE — PROFESSION — DATE

Dallas county Mental Health and Mental Retardation center

TRANSFER/DISCHARGE SUMMARY

PAGE 2

Yokamon Hearn
CLIENT NAME

154215
CASE NUMBER

FOR DISCHARGES, ADDRESS THE FOLLOWING:

1. COURSE OF TREATMENT (WHAT HAPPENED IN TREATMENT, SERVICES RENDERED, EXTENT OF GOAL ATTAINMENT)

Yokamon was in for two family therapy sessions. He denied having any more suicidal ideations. His mother has a problem with drug abuse and could not be relied upon to bring him in.

2. PREVIOUS TREATMENT HISTORY

PLACE	BEGAN	ENDED	PLACE	BEGAN	ENDED
none					

3. AFTERCARE NEEDS: None

Debra Coffey, CSW-ACP
SIGNATURE PROFESSION

4/13/89
DATE

Last 5/2/89

dallas county Mental Health and Mental Retardation center

TRANSFER/DISCHARGE
SUMMARY
PAGE 1

CLIENT NAME: Hearn, Yokamon
AGE: 10
ADMISSION DATE: 1-16-89
O. U. NAME: Central C/A

CASE NUMBER: 154215
SEX: M
CLOSING DATE: 4/13/89
CASE MANAGER: Debra Coates

ACTION:
☐ TRANSFER WITHIN AGENCY (COMPLETE PAGE 1 ONLY) → UNIT REFERRED TO
☑ DISCHARGE FROM AGENCY (COMPLETE PAGES 1 & 2) → APPOINTMENT DATE AND TIME

FOR TRANSFERS AND DISCHARGES, ADDRESS THE FOLLOWING SIX ITEMS:

1. REASON FOR ADMISSION
2. PRESCRIBED MEDICATIONS AT TIME OF TRANSFER/DISCHARGE
3. RECOMMENDATIONS FOR FUTURE TREATMENT (TRANSFERS ONLY)

1. Suicidal ideations
2. none

4. REASON FOR TRANSFER/DISCHARGE: ☐ MAXIMUM BENEFIT ACHIEVED ☐ CLIENT WITHDREW
WAS THIS AGAINST PROFESSIONAL ADVICE? ☐ YES ☐ NO
☐ MOVED ☐ DIED ☑ OTHER failure to keep appts
SPECIFY

5. DIAGNOSIS: DSM-III

		CODE
AXIS I	Adjustment disorder with depression	309.00
AXIS II	Deferred	
AXIS III	None	

AXIS IV: 4
1 NONE 5 EXTREME
2 MILD 6 CATASTROPHIC
3 MODERATE 0 INADEQUATE/NC
4 SEVERE

AXIS V-GLOBAL ASSESSMENT OF FUNCTIONING:
52 CURRENT, 70 PAST YEAR

6. ALLERGIES:

Debra Coates, CSW-ACP
SIGNATURE PROFESSION
DATE 4/13/89

[illegible signature] 5/1/89

TREATMENT PLAN

CLIENT NAME: Yokanon Hearn CLIENT #: 154215

UNIT NAME: Adutic St C/A

DATE OF ADMISSION: 1/16/89 DATE OF TREATMENT PLAN: 1/26/89

(If Date of Treatment Plan is more than 30 days after Date of Admission for Outpatient or Day Treatment Services, or more than 7 days for Inpatient Services, provide explanation:)

PROBLEM: suicidal note. stating desire to die.

GOALS AND OBJECTIVES (Specify problem-related goals to attain, maintain, and/or re-establish emotional and/or physical health, as well as growth and adaptive capabilities; and specify goal-related objectives, each of which is written in measurable terminology, focusing on identified problem(s), and including an expected achievement date):

mother wants to work on communication skills for both she and Yokanon. Currently he does not share his feelings with her and she wants him to be able to do this. The goal will be to help Yokanon become more aware of his feelings and how to express them. Also his mother will begin expressing her feelings through trusting others and allowing herself to own the feelings she has rather than block them.

INTERVENTION STRATEGIES (Specify intervention strategies for achieving objectives, agent(s) responsible for each strategy, and expected achievement dates):

	PERSON RESPONSIBLE	EXPECTED ACHIEVEMENT DATE
___ Inpatient Crisis Stabilization		
___ Outpatient Crisis Stabilization		
___ Day Treatment		
___ Individual Psychotherapy		
✓ Family Therapy	Debra Coates, CSW-ACP	1/26/89
___ Group Therapy		
___ Couple/marital Therapy		
___ Play Therapy		
___ Chemotherapy		
___ Parent Training		
___ Other (Specify:)		

COMMENTS RE INTERVENTION STRATEGIES (Elaborate as needed on intervention strategies. As appropriate, specify conditions, activities, or barriers which interfere with achieving objectives):

Yokemon is not suicidal although he did write a note saying he wished he was dead. He does not seem to have adequate skills for expressing himself mostly because it seems his mother cuts him off when he is doing it naturally.

IS THIS PROBLEM AREA REFLECTED IN THE ASSESSMENT? ✓ Yes ___ No (If No, explain ___)

IS CLIENT AND/OR GUARDIAN IN AGREEMENT WITH PLAN? ✓ Yes ___ No (If No, explain ___)

NEXT TREATMENT PLAN REVIEW DATE: 6/89

Client — Client's Legal Representative: David Hearn

Case Manager: Debra Carter, CSW-ACP — Psychiatrist

Clinical Supervisor: Neil Johnson, Psy Coordinator — Staff

Staff — Staff

TREATMENT PLAN REVIEW/UPDATE

Specify Progress to date and Further Objectives:

NEXT TREATMENT PLAN REVIEW DATE:

Client — Client's Legal Representative

Case Manager — Psychiatrist

Clinical Supervisor — Staff

* FILE IN SEC. 5 * "FACTS" COPYRIGHT 1983 TEXMHMR * DIAGFRRC R-05/10/83

DSM-III-R DIAGNOSTIC FORM

CLIENT ID: 15425 NAME: Hearn Yokamon DATE: 01/16/89 9:22 A/P

STAFF COMPLETING: Margie Mejia STAFF ID: 90996 R.U.: 0621

ACTION: (1)-ADMISSION 2-REEVALUATION 3-DEATH 4-DISCHARGE 9-LOF

PRINCIPAL DIAGNOSIS: (1-AXIS I, LEVEL 1) (2-AXIS II, LEVEL 1)

--- DSM-III ---

AXIS I - CLINICAL SYNDROMES AND V CODES:

1. 30900 Adjustment D.O. W/Depressed Mood
2.
3.
4.
5.
6.

AXIS II - DEVELOPMENTAL DISORDERS AND PERSONALITY DISORDERS:

1. 79990 Dx Deferred
2.
3.
4.

AXIS III - PHYSICAL DISORDERS AND CONDITIONS (ICD-9):

1. NONE
2.
3.
4.
5.
6.

AXIS IV - SEVERITY OF PSYCHOSOCIAL STRESSORS:
1-NONE 2-MILD 3-MODERATE (4-SEVERE) 5-EXTREME 6-CATASTROPHIC 0-INADEQUATE/ N C

AXIS V - GLOBAL ASSESSMENT OF FUNCTIONING:

CURRENT: 50 PAST YEAR 70

IBL CODE (MR ONLY):
CURRENT: 0-NONE 1-MILD 2-MODERATE 3-SEVERE 4-PROFOUND
POTENTIAL: 0-NONE 1-MILD 2-MODERATE 3-SEVERE 4-PROFOUND

LEVEL OF FUNCTIONING: 1 2 3 4 5 6 7 8 9

TDMHMR ADMISSION: 1-YES (2-NO) FAC.- _____ CODE-____ DATE-__/__/__

CASE MANAGEMENT: SCREENED: (1-YES) 2-NO ELIGIBLE: 1-YES (2-NO)

MAMD: PRIMARY- __ __ __ SECONDARY- __ __ __ TERTIARY- __ __ __
GENETIC- __ __ PERCEPTION- __ __ MOTOR DYSFUNCTION- __ __ __ __
CRANIAL ANOMALY- __ __ CONVULSIVE DISORDER- __ __
SENSORY IMPAIRMENT- __ __ PSY IMPAIRMENT- __ __

IQ SCORE: __ __ __ IQ TEST TYPE: ____ SQ SCORE: __ __ __ SQ TEST TYPE: ____

Margie Mejia
STAFF COMPLETING FORM

Dr. Chua
PHYSICIAN

Margie Mejia
CASE MANAGER

QUERY: Referred PMH Mitch - client seen 1-10-89 at 7 pm - no meds - ref by school for suicidal ideation client wrote note "I wish I die tonight & never see the world again". This in response to favorite teacher leaving. A, B student - no behavioral problems at home or school - client said he no longer wanted to die after he had a talk at school he previous hx of problem

EXHIBIT 7

DALLAS COUNTY HOSPITAL DISTRICT
DALLAS, TEXAS

PROGRESS NOTES

OUTPATIENT DEPARTMENT

00 54 55 85 R 02
HEARN, SUSAN DIANNE
01155762 17 EX 11/21/97
[redacted] EL F 0596 OHP
[redacted] A 02
1211 BRYAN ST 01
DALLAS TX 75204
9/30/97

To whom it may concern:

Ms. Hearn suffers from migraine headaches which can be severe and disabling at times.

We have many medications to treat this condition, and we are in the process of searching for the most effective therapy for Ms. Hearn.

Thank you for your patience.

Sincerely,

Susan Egner, MD

DALLAS COUNTY HOSPITAL DISTRICT PROGRESS NOTES — OUTPATIENT DEPARTMENT

GUARANTOR NAME	GUARANTOR PHONE	MEDICARE NO.	MEDICAID NO.
INSURANCE COMPANY HEARN, SUSAN DIANNE	GROUP NUMBER 214-827-0177	POLICY/CERTIFICATE NO	CONTRACT NO.
NAME OF INSURED PREPAY DALLAS COUNTY	EMPLOYER OF INSURED	PATIENT PHONE	
INSURED EMPLOYER'S ADDRESS HEARN, SUSAN DIANNE	DALLAS MORNING NEWS	STATE	ZIP CODE 214-827-0177 ACCIDENT RELATED YES NO

PLANO PRKWY PLANO **DEPT.** PHYSICIAN Epner

MRN # 00000054558S ACC # 000115576217 DIAGNOSIS

SERVICE DATE 09/30/97 CASHIER LOCATION

HEARN, SUSAN DIANNE BI F DX 11/21/97 LOCATION CMDF

F/C 02 [redacted] 1344 CLINIC CLERK allergies NKA

4511 BRYAN ST DALLAS TX 75204 MVM

NEUROLOGY CLINIC DATE: ~~9/30/97~~ WT: 132 Bp 110/70

37yo RH BE h/o migraine HA x 20y's occ c blurred vision, strokes c migraines (3) arms numb (R) before (2), legs numb Reports 4x/week HA, photophobia, hurts "everywhere" on head. Rare N/V c HA Visual phenomenon (sees tiny stars occ before Head hurts) Φ h/o SZ Before the propranolol ~~40~~ HA gd No known precipitant

PMHΦ HA caused generalized weakness, not focal weakness FH 2 sisters c migraine Φ SZ

Meds

Midrin

propranolol ~~40mg tid gd~~ ↑ 40mg tid (x ~ 2mo)

CT heads – neg (11/96)

Sx Φ alc Φ tob 2 pp week

Dallas morning news – c machines

I GRANT PERMISSION TO THE MEDICAL STAFF OF DALLAS COUNTY HOSPITAL DISTRICT TO PERFORM ANY MEDICAL OR SURGICAL TREATMENT AND TO ADMINISTER SUCH ANESTHETICS AND/OR DRUGS AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND TREATMENT OF SAID PATIENT. FURTHERMORE I STATE THAT THE ABOVE AND FOREGOING FACTS AND INFORMATION ARE TRUE AND CORRECT TO MY PERSONAL KNOWLEDGE

SIGNATURE

WITNESS

I PROMISE AND AGREE TO PAY PARKLAND MEMORIAL HOSPITAL ALL CHARGES ACCRUING AS A RESULT OF THIS ADMISSION UPON RECEIPT OF STATEMENT. IT IS SPECIFICALLY UNDERSTOOD AND AGREED THAT ALL PAYMENTS WILL BE MADE TO THE BUSINESS OFFICE, PARKLAND MEMORIAL HOSPITAL, 5201 HARRY HINES BLVD., DALLAS, TEXAS, AND

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED HOSPITAL OF THE HOSPITAL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME BUT NOT TO EXCEED THE BALANCE DUE OF THE HOSPITAL'S REGULAR CHARGES FOR THIS PERIOD OF HOSPITALIZATION. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE HOSPITAL FOR THESE CHARGES, AND

I HEREBY AUTHORIZE RELEASE BY THE HOSPITAL OF INFORMATION REQUESTED BY MY INSURANCE COMPANIES.

SIGNATURE Epner MD

DALLAS COUNTY HOSPITAL DISTRICT
DALLAS, TEXAS

PROGRESS NOTES
OUTPATIENT DEPARTMENT
NEUROLOGY

00 54 55 85 R 02
HEARN, SUSAN DIANNE
01155 5217 EX 11/21/97
[redacted] BL F 0596 DHP
A 02
4511 BRYAN ST 01
DALLAS TX 75204

PE
Sensory V1, V2 (R) sharper
(R) foot ↑ PP

Gait WNL HEENT EOMI PERRL fundi benign
Motor 5/5 UE/LE
CN otw intact
Coord F→N intact (B)

Gait mildly wide based
heel/toe OK tandem OK

(AP) 0 Complicated migraine - exam c patchy (R) sided hyperesthesia

Plan - • d/c propranolol
• Begin sumatriptan (imitrex) 25mg po x 1 at onset may repeat q2° 50mg upto 300mg qd
• d/c Midrin as ◊ fair response
• Consider ~~repeat~~ adding different agent for prophylaxis (Verapamil or TCA) if needed.

RTC 1 mo
◊ discussed lifestyle
Avoid smoking
excessive caffeine

DATE: SEP 3 0 1997 TIME:	COMMENTS	YES	NO	N/A
Circle if applicable				
Tests, Treatment / Results given to pt				
Medication / Side Effects				
Discharge: Inst / Referral / Handouts				
Pt Verbalize: Understanding / Questions / Concerns				
Emergency Precautions				
Pt Discharge to: Home / Facility				
MD Signature:	Initials:			
RN Signature:	Initials:			

FORM •52350 REV 4/79

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

CONSENTS AND AUTHORIZATIONS

00 54 55 85 K 02
HEARN, SUSAN DIANNE
01155 5217 EX 11/21/97
[redacted] 3L F 0596 DHP

CONSENT FOR MEDICAL TREATMENT

I do hereby voluntarily consent to and authorize the Dallas County Hospital District (DCHD) to provide care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the attending physician and/or his/her designees.

SH Initials

AUTHORIZATION TO PAY BENEFITS TO DALLAS COUNTY HOSPITAL DISTRICT

I authorize payment directly to the DCHD of all benefits otherwise payable to me or for me by any third party payor.

SH Initials

I understand I am financially responsible to the DCHD for charges not covered by third party payors.

SH Initials

I understand that I shall be billed separately for professional services rendered by each physician or other health care provider.

SH Initials

I hereby authorize DCHD to release any medical information to any third party payor pertaining to my diagnosis and treatment within the DCHD. This may include, but not be limited to, information concerning communicable diseases, laboratory test results, medical history, treatment progress, or any other such related information requested.

SH Initials

I understand that this authorization is valid for the time period which is consistent with the Medical Record Department policy of the DCHD or until the medial claim has been paid, whichever is longer.

SH Initials

AUTHORIZATION TO RELEASE INFORMATION

I authorize DCHD to confirm my presence and release a one word condition statement, such as, "Critical, Serious, Fair, or Good."

SH Initials

I authorize DCHD to release health care information, including medical history, diagnosis, treatment, or prognosis, to my next of kin and/or the following person. List Names

SH Initials

_____

I have read and understand the above consent and authorizations.

X Susan Hearn — Signature *(Patient, Guardian, or Legally Authorized Representative)*

X 9/30/97 — Date

Relationship to patient _____

DCHD Representative/ID Number VQ7016 Language Assist./ID Number _____

STATEMENT OF PATIENT LEAVING AGAINST MEDICAL ADVICE

I am the responsible party and am removing the patient, _____ from the Dallas County Hospital District and I hereby assume any and all responsibility for accident and illness attending or following the above named patient's discharge from the Dallas County Hospital District. I acknowledge liability for all incurred expenses.

Susan Hearn — Signature *(Patient, Guardian, or Legally Authorized Representative)*

Date

Relationship to patient _____

DCHD Representative/ID Number _____

For DCHD Use Only: _____

E46

PS 845 8/98

DATE 06/97 | ADMIT TIME 15:26

DALLAS COUNTY HOSPITAL DISTRICT
EMERGENCY DEPARTMENT ADMISSION

ER MD 10684 | SERVICE 4020

LAST	FIRST	MIDDLE	MAIDEN	ACCOUNT #	MR #
[redacted]N,	SUSAN	DIANNE	ROSS	000116599556	000000545585

ADDRESS	APT#	CITY	STATE	ZIP	COUNTRY
4511 BRYAN ST		DALLAS	TX	75204 - 6864	057

PHONE	BIRTH DAY	AGE	SEX	RACE	MAR STAT	SOC SEC#	REFERRING PHYSICIAN OR MEDICAL FACILITY	ARR MEANS	CRIME VICTIM	POLICE NOTIF
214-827-0177	[redacted]	037	F	BL	P	[redacted]		SE		

AMBULANCE #	TYPE	LOCATION OF ACCIDENT	ACCIDENT DATE	ACC TIME

EMPLOYER

EMPLOYER	EMPLOYER ADDRESS
DALLAS MORNING NEWS	[redacted]

EMPLOYER CITY	STATE	ZIP	EMPLOYER PHONE	EXT	WRK REL
PLANO	TX	- 0000	000-000-0000		

GUARANTOR

GUARANTOR'S NAME	GUARANTOR'S ADDRESS	APT. #
HEARN, SUSAN DIANNE	4511 BRYAN ST	

GUARANTOR'S CITY	STATE	ZIP	PHONE - HOME
DALLAS	TX	75204 - 6864	214-827-0177

GUARANTOR'S EMPLOYER	PHONE - BUSINESS	RELATIONSHIP TO PATIENT
DALLAS MORNING NEWS	000-000-0000	SELF

NEXT OF KIN

NEXT OF KIN	NEXT OF KIN - ADDRESS	PHONE - HOME
JOHNSON, MICHAEL	[redacted]	214-827-0177

NEXT OF KIN - CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	PHONE - BUSINESS
DALLAS	TX	75204 - 6864	HUSBAND	000-000-0000

CONTACT

LOCAL CONTACT	LOCAL CONTACT ADDRESS	PHONE - HOME
SHEPPARD, MARY	[redacted]	214-827-5988

LOCAL CONTACT - CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	PHONE - BUSINESS
DALLAS	TX	75241 - 0000	FRIEND	

INSURANCE

INSURANCE COMPANY	CO/PLN	GROUP NAME	GROUP #	PLAN CODE
PEND-DCLAR	29/001	N / A	N / A	N/A

EFFECTIVE DATE	NAME OF INSURED	I.D. #	AUTHORIZATION #	CERT DATE
/ /	N / A		N / A	

DX

PROBLEM/CHIEF COMPLAINT	COND	S1	S2	S3	LAST DC DATE	FNI CLS	ADM BY
HEADACHE	2	A				29	DW

CONSENT FOR TREATMENT/RELEASE OF RESPONSIBILITY FOR VALUABLES

I grant permission to the medical staff of the Dallas County Hospital District to perform any medical or surgical treatment and to administer such anesthestics and/or drugs as may be deemed necessary in the diagnosis and treatment of said patient. Futhermore I state that all patient information is true and correct to my personal knowledge, I also release the Dallas County Hospital District from all responsibility for any valuables and personal articles that are not checked in by the hospital staff.

SIGNED: _____ RELATIONSHIP IF OTHER THAN PATIENT IS SIGNING: _____

WITNESS: _____ TIME: _____

LEAVING AGAINST MEDICAL ADVISE

I am the responsible party and am removing the patient, _____, from the Dallas County Hospital District and I hereby assume any and all responsibility for accident and illness attending or following the above named patient's discharge from the above named institution. I acknowledge liability for all incurred expenses, including all Emergency Room fees.

SIGNED: _____ RELATIONSHIP IF A MINOR: _____

MD SIGNATURE: _____ DATE: _____ TIME: _____

TEMPORARY ABSENCE RELEASE

I have obtained permission from the attending physician to be absent from the Emergency Dept. for my convenience from:

TIME: _____ DATE: _____ to TIME: _____ DATE: _____

I assume all responsibility for the named patient, during this temporary absence and hereby release the Dallas County Hospital District, its employees and the attending physician from all responsibility during this absence and for my or the patient's condition as a result thereof.

SIGNED: _____ RELATIONSHIP IF A MINOR: _____

MD SIGNATURE: _____ DATE: _____ TIME: _____

ADMIT DATE	ADMIT TIME
07/06/97	15:26

DALLAS COUNTY HOSPITAL DISTRICT
EMERGENCY DEPARTMENT ADMISSION

ER MD	SERVICE
10684	4020

PATIENT

NAME (LAST, FIRST, MIDDLE)	MAIDEN	ACCOUNT #	MR #
HEARN, SUSAN DIANNE	ROSS	000116599556	000000545585

ADDRESS	APT#	CITY	STATE	ZIP	COUNTRY
4511, BRYAN ST		DALLAS	TX	75204 - 6864	057

PHONE	BIRTH DAY	AGE	SEX	RACE	MAR STAT	SOC SEC#	REFERRING PHYSICIAN OR MEDICAL FACILITY	ARR MEANS	CRIME VICTIM	POLICE NOTIF
214-827-0177	[redacted]	037	F	BL	P	[redacted]		SE		

AMBULANCE #	TYPE	LOCATION OF ACCIDENT	ACCIDENT DATE	ACC TIME

EMPLOYER

EMPLOYER	EMPLOYER ADDRESS
DALLAS MORNING NEWS	[redacted]

EMPLOYER CITY	STATE	ZIP	EMPLOYER PHONE	EXT	WRK REL
PLANO	TX	- 0000	000-000-0000		

GUARANTOR

GUARANTOR'S NAME	GUARANTOR'S ADDRESS	APT. #
HEARN, SUSAN DIANNE	[redacted]	

GUARANTOR'S CITY	STATE	ZIP	PHONE - HOME
DALLAS	TX	75204 - 6864	214-827-0177

GUARANTOR'S EMPLOYER	PHONE - BUSINESS	RELATIONSHIP TO PATIENT
DALLAS MORNING NEWS	000-000-0000	SELF

NEXT OF KIN

NEXT OF KIN	NEXT OF KIN - ADDRESS	PHONE - HOME
JOHNSON, MICHAEL	[redacted]	214-827-0177

NEXT OF KIN - CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	PHONE - BUSINESS
DALLAS	TX	75204 - 6864	HUSBAND	000-000-0000

CONTACT

LOCAL CONTACT	LOCAL CONTACT ADDRESS	PHONE - HOME
SHEPPARD, MARY	[redacted]	214-827-5988

LOCAL CONTACT - CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	PHONE - BUSINESS
DALLAS	TX	75241 - 0000	FRIEND	

INSURANCE

INSURANCE COMPANY	CO/PLN	GROUP NAME	GROUP #	PLAN CODE
PEND-DCLAR	29/001	N / A	N / A	N/A

EFFECTIVE DATE	NAME OF INSURED	I.D. #	AUTHORIZATION #	CERT DATE
/ /	N / A		N / A	

DX

PROBLEM/CHIEF COMPLAINT	COND	S1	S2	S3	LAST DC DATE	FNT CLS	ADM BY
HEADACHE	2	A				29	DW

CONSENT FOR TREATMENT/RELEASE OF RESPONSIBILITY FOR VALUABLES

I grant permission to the medical staff of the Dallas County Hospital District to perform any medical or surgical treatment and to administer such anesthestics and/or drugs as may be deemed necessary in the diagnosis and treatment of said patient. Futhermore I state that all patient information is true and correct to my personal knowledge, I also release the Dallas County Hospital District from all responsibility for any valuables and personal articles that are not checked in by the hospital staff.

SIGNED: _____ RELATIONSHIP IF OTHER THAN PATIENT IS SIGNING: _____

WITNESS: _____ TIME: _____

LEAVING AGAINST MEDICAL ADVISE

I am the responsible party and am removing the patient, _____, from the Dallas County Hospital District and I hereby assume any and all responsibility for accident and illness attending or following the above named patient's discharge from the above named institution. I acknowledge liability for all incurred expenses, including all Emergency Room fees.

SIGNED: _____ RELATIONSHIP IF A MINOR: _____

MD SIGNATURE: _____ DATE: _____ TIME: _____

TEMPORARY ABSENCE RELEASE

I have obtained permission from the attending physician to be absent from the Emergency Dept. for my convenience from:

TIME: _____ DATE: _____ to TIME: _____ DATE: _____

I assume all responsibility for the named patient, during this temporary absence and hereby release the Dallas County Hospital District, its employees and the attending physician from all responsibility during this absence and for my or the patient's condition as a result thereof.

SIGNED: 7/6/97 RELATIONSHIP IF A MINOR: _____

MD SIGNATURE: _____ DATE: _____ TIME: _____

FORM 580002 REV 12/91 O: I: E:

MEDICAL RECORD

17.

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

DEPARTMENT OF EMERGENCY SERVICES
PHYSICIAN REPORT

07 54 55 35 F 27
..LANN, SUSAN DIANNE
0111599556 AD 07/06/37
[redacted] FL F 12641 4020
A 29
01
10684

ALLERGIES: NKDA

INITIAL VITAL SIGNS TIME: 1518 T 36.8 P 95 R 20 BP 132/93

COMPLAINT: HA

PHYSICIAN NOTES TIME SEEN: ______ HA x 2 days

HISTORY:
Pt is a 37 y/o BF c̄ h/o migraine HAs for 20 yrs presents c̄ HA. Normal migraine pattern includes difficulty speech and numbness on Ⓛ side. This symptom complex began yesterday took Imitrex yesterday, [illegible]

HEENT:
all associated c̄ photophobia; ⊕ N/V → HA Ⓡ sided retroorbital

NECK

PE: Thin BF in obvious discomfort c̄ slow difficult speech

CHEST

1996: Spoke c̄ pt – H/o gone; Pt hungry. Pt has appt Neurology clinic in Sept. Pt takes Imitrex for migraines + if doesn't work comes to ED.

meds
– Imitrex
– [struck through]
Synthroid
LMP / s/p hysterectomy
All
NKDA

HEART

ABD

PE: HEENT: PERRLA, EOMI; Fundi flat s̄ hem, hemorrhages; [illegible], [illegible]
Neck: Ⓝ lymphadenopathy
CV: RRR s̄ M
Lungs: CTA A-P/R

EXT

NEURO.

VASCULAR

☐ SEE CONT. SHEET

LAB/RADIOLOGY ORDERS (CIRCLE)

CBC-DIFF	UA	GLU	CREAT
PT—PTT	ABG	RPR	TOX
CARDIAC ENZYMES		LIVER BATTERY	
CA	MG	PO4	I&C: ____
ETOH	AMYLASE	G&S	
LYTES, BUN, EKG			
OTHER: ____			
X RAY: ____			

TIME	ORDERS
	Imitrex 6mg SQ
[illegible]	
	[signature]
	DC to home
	T Rossini

CONSULT/ADMIT SERVICES

SERVICE	TIME CALLED	TIME IN DEPT.

DIAGNOSIS: Migraine

DIAGNOSIS CODE:

MD SIGNATURE: T Rossini MD

MD PRINTED NAME: TOM ROSSINI

FACULTY SIGNATURE:

DISCHARGE PLAN / RX GIVEN / FOLLOW-UP
1) Midrin # tabs PO followed by 1 q 1° until relief up to 5/12 hr period
2) RTER if Midrin doesn't work

DISPOSITION: ☒ HOME ☐ AMA ☐ AWOL ☐ ADMIT (SERVICE: ______) TRANSFER TO: ______

CONDITION: ☒ IMPROVED ☐ UNCHANGED ☐ EXPIRED TIME ______ AM/PM DATE: ______

005

55690 Revised 12/91

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

EMERGENCY SERVICES DEPARTMENT
MEDICINE PATIENT ASSESSMENT FORM

DIANNE
AD 07/06/97
[redacted] F 12641 4030
A 29
01
10634

INITIAL ASSESSMENT TIME 1518 DATE 07/6/97 ARRIVED: AMBULATORY ✓ NON-AMBULATORY ____

ALLERGIES: NKDA

CHIEF COMPLAINT: H. A.

LEVEL OF CARE (circle) 1 (2) 3 4 5

NURSING ASSESSMENT: x 2 days c Hx migraines unrelieved by midrin. C/O (R) sided numbness c weakness x 3-4 hours. ... grip strength weak on right. pt. has taken several bottles c ~~[struck]~~ has visible tremors for 3 days. ... / Skin w/d

VITAL SIGNS

TIME	B/P	TEMP	PULSE	RESP	O_2 SAT	D-STIX	INIT
1518	137/92	98	95	20	99		[initials]

MEDICAL HISTORY (+) YES (-) NO

CARDIAC		HTN	
COPD/ASTHMA		RENAL	
DIABETES		IDP	
SEIZURE DISORDER	+	OTHER (describe)	migraines

CURRENT MEDICATIONS

Midrin

PATIENT VALUABLES / BELONGINGS

With Patient ____ With Family ____ Cashier ____

IMMUNIZATIONS REVIEWED: YES ____ NO ____ N/A ____

IMMUNIZATION REFERRAL SHEET GIVEN: YES ____ NO ____

PATIENT REFERRALS

TYPE:

INTAKE

TIME	#IV	SITE	GAUGE	TYPE FLUID	VOLUME/ TOTAL	INIT

INTAKE

TIME	TYPE	VOLUME/TOTAL	INIT.

PATIENT RESPONSE

PREGNANT: ☐ YES ☐ NO ☐ UNK ☐ N/A

SIGNATURE/ID #: [signature] 10129 R.N.

MEDICATIONS ADMINISTERED

DRUG	DOSAGE	ROUTE/ SITE	TIME	PLUG FLUSHED	INIT.
1045 Imitrex	6mg	SQ			[initials]

RN / LVN / PCT INITIALS / ID # [initials] / ID # 3147 / ID # / ID # / ID #

SIGNATURE: [signature] 3147

006

DALLAS COUNTY HOSPITAL DISTRICT

DALLAS, TEXAS

EMERGENCY ROOM RECORD

CONTINUATION

54 ... 25 ... 2
..., SUSAN DIANNE
0115599555b AD 07/06/97
[redacted] F 12641 4020
A 29
10684 01

NAME: Last First Middle

Emergency Room Number: Date

Time Ordered	Medications and Treatments (continued)
1615	Pt. to #17 in MER. Pt cont. c/o HA unrelieved
	by Midrin. Pt. c/o weakness to Ⓡ side Ⓡ
	grip somewhat weak. Pt tearful. ——— [signature]
2005	D/c c d3 then A&Ox3 resp [illegible]
	MAEW headache resolved ——— [signature] 10/29

006

FORM NO. 55090 (REV. 2/77)

MEDICAL RECORDS

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

DEPARTMENT OF EMERGENCY SERVICES
AFTER CARE INSTRUCTIONS

[redacted]

IMPORTANT: We have examined and treated you today on an emergency basis only. This is not a substitute for, or an effort to provide complete medical care. In most cases you must let your private doctor check you again. If you have been referred to a clinic, we strongly recommend that you keep your appointment. If you have had special tests such as EKG's, X-rays or labs we will review them again. We will attempt to call you if there are any suggestions. After leaving, follow the instructions listed below.

DIAGNOSIS: Migraine

MEDICATION:

FOLLOW LABEL INSTRUCTIONS FOR ANY PRESCRIPTION GIVEN BY EMERGENCY PHYSICIAN

☐ TAKE ANTIBIOTICS UNTIL GONE

PREPRINTED INSTRUCTIONS GIVEN: ☐ YES ☐ N/A

IN SPANISH: ☐ YES ☐ N/A

☐ BACTRIM	☐ PENICILLIN
☐ CLOTRIMAZOLE VAGINAL CREAM/TAB	☐ PHENOBARBITAL
☐ DOXYCYCLINE	☐ PREDNISONE
☐ DILANTIN	☐ TETRACYCLINE
☐ ERYTHROMYCIN	☐ TYLENOL #3
☐ IBUPROFEN/MOTRIN	☐ VERAPAMIL
☐ FLAGYL	☐ ZANTAC
☐ KEFLEX	☐ _____
☐ LASIX	☐ _____
☐ ROBAXIN	☐ _____

DEMONSTRATED/PREPRINTED INSTRUCTIONS GIVEN

☐ ABDOMINAL WARNINGS
☐ BURN CARE
☐ CAST CARE
☐ CRUTCH TRAINING
☐ D&C FOLLOW-UP
☐ DRESSING CHANGE
☐ FOOT CARE
☐ HEAD INJURY
☐ SUTURE CARE
☐ WOUND CARE
☐ WET TO DRY DRESSING
☐ OTHER _____

OTHER RESOURCES

☐ DENTAL CLINIC REFERRAL
☐ HEALTH DEPT. REFERRAL
☐ HOMELESS REFERRAL
☐ SOCIAL SERVICES REFERRAL
☐ FAMILY PLANNING REFERRAL

SPECIAL INSTRUCTIONS: (1) medication as directed
(2) return if headache does not resolve with medication

FOLLOW-UP/CLINIC APPOINTMENT GIVEN ☐ YES ☑ N/A **PRESCRIPTION GIVEN:** ☑ YES ☐ N/A

I HAVE RECEIVED AND UNDERSTAND THE INSTRUCTIONS ABOVE. I UNDERSTAND THAT I HAVE HAD EMERGENCY TREATMENT ONLY. I WILL ARRANGE FOR FOLLOW-UP CARE AS INSTRUCTED AND I WILL CAREFULLY FOLLOW THE INSTRUCTIONS GIVEN.

TRANSLATOR USED: ☐ YES ☑ N/A

DISCHARGED: ☑ HOME ☐ OTHER _____ (X) Susan Heard
PATIENT/SIGNIFICANT OTHER SIGNATURE

☑ AMBULATORY ☐ WHEELCHAIR ☐ OTHER _____

RN/MD SIGNATURE: [signature] CMA DATE: 7/6/92 TIME: 2007

UNAVAILABLE FOR DISCHARGE TEACHING: 1) _____ TIME/INITIAL 2) _____ TIME/INITIAL 3) _____ TIME/INITIAL

006A

PS 149 Revised 9/92 White Copy - Medical Record Yellow Copy - Patient's Copy

INPATIENT–FILE WITH ADMINISTRATIVE RECORDS ON FRONT CLIP

DALLAS COUNTY HOSPITAL DISTRICT

DALLAS, TEXAS

WORK/SCHOOL RELEASE AND APPOINTMENT VERIFICATION

[redacted] 54 55 85 [redacted]
[redacted] ARN, SUSAN DIANNE
[redacted] 11659956 [redacted]
[redacted] BL [redacted]
[redacted] A
[redacted] P4 O

APPOINTMENT VERIFICATION

This is to indicate that [redacted] SUSAN HEARN

has been seen in the DMH Medicine ESD (TREATMENT AREA) of Dallas County Hospital District on 7/6/97 (DATE)

J. MINICK RN
PRINTED NAME

[redacted] RN
SIGNATURE

Date: 7/6/97

MEDICAL RELEASE/RESTRICTIONS

This patient is considered ready to return to work/school on _____

_____ MD
PRINTED NAME

_____ MD
SIGNATURE

Date: _____

OUTPATIENT–FILE BEHIND SOCIAL HISTORY RECORDS ON FRONT CLIP

N35

FORM NO. 52820 (REV. 9/87) WHITE COPY – CHART YELLOW COPY – PATIENT

DALLAS COUNTY HOSPITAL DISTRICT PROGRESS NOTES — OUTPATIENT DEPARTMENT

GUARANTOR NAME: HEARN, SUSAN DIANNE	GUARANTOR PHONE: 214-827-6177	MEDICARE NO.	MEDICAID NO.
INSURANCE COMPANY: PREPAY DALLAS COUNTY	GROUP NUMBER	POLICY/CERTIFICATE NO.	CONTRACT NO.
NAME OF INSURED: HEARN, SUSAN DIANNE	EMPLOYER OF INSURED: DAILY MORNING NEWS	PATIENT PHONE: 214-827-6177	
INSURED EMPLOYER'S ADDRESS: PLANO PKWY	PLANO	TX STATE	ZIP CODE

ACCIDENT RELATED YES X NO

MRN # 000000545585 ACC # 000115574217

HEARN, SUSAN DIANNE BI F DX 11/21/97

DOB 02 06/14/60 1339

4511 BRYAN ST DALLAS TX 75204

DEPT. GMDF

SERVICE DATE 11/21/97

LOCATION PHN

PHYSICIAN: Ephraim Wang

DIAGNOSIS

CASHIER LOCATION

CLINIC CHART: allergies NKA

NEUROLOGY CLINIC DATE: 6/21/97 WT: 130 lbs BP 110/60

36 y/o RHDF c Hx of complicated migraine for 20 yrs presents here for F/U. She was on propranolol 80 mg po qd, prescribed by Dr. Ephraim, which helps. Her frequency is down to 1/wk from 3/wk. But propranolol was d/c'ed by some doctor.

Neuro exam: A+Ox3, non-focal

A/P: complicated migraine

1. Will restart propranolol 80 mg po qd.
2. Cont Midrin for H/A
3. F/u in 3 months

Ephraim Wang 2007

I GRANT PERMISSION TO THE MEDICAL STAFF OF DALLAS COUNTY HOSPITAL DISTRICT TO PERFORM ANY MEDICAL OR SURGICAL TREATMENT AND TO ADMINISTER SUCH ANESTHETICS AND/OR DRUGS AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND TREATMENT OF SAID PATIENT. FURTHERMORE I STATE THAT THE ABOVE AND FOREGOING FACTS AND INFORMATION ARE TRUE AND CORRECT TO MY PERSONAL KNOWLEDGE

SIGNATURE

WITNESS

I PROMISE AND AGREE TO PAY PARKLAND MEMORIAL HOSPITAL ALL CHARGES ACCRUING AS A RESULT OF THIS ADMISSION UPON RECEIPT OF STATEMENT. IT IS SPECIFICALLY UNDERSTOOD AND AGREED THAT ALL PAYMENTS WILL BE MADE TO THE BUSINESS OFFICE, PARKLAND MEMORIAL HOSPITAL, 5201 HARRY HINES BLVD., DALLAS, TEXAS; AND

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED HOSPITAL OF THE HOSPITAL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME BUT NOT TO EXCEED THE BALANCE DUE OF THE HOSPITAL'S REGULAR CHARGES FOR THIS PERIOD OF HOSPITALIZATION. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE HOSPITAL FOR THESE CHARGES; AND

I HEREBY AUTHORIZE RELEASE BY THE HOSPITAL OF INFORMATION REQUESTED BY MY INSURANCE COMPANIES

SIGNATURE

PROGRESS NOTES – OUTPATIENT DEPARTMENT

Neurology staff

I examined & interviewed this pt.

36 y.o Woman with history of Migraine ~~[illegible]~~ with

~~with~~ a good response to Inderal 80mg [illegible]

4 weeks. Will ↑ Inderal to 120mg qday.

— H. [signature]

01018

DALLAS COUNTY HOSPITAL DISTRICT

DALLAS, TEXAS

PROGRESS NOTES

OUTPATIENT DEPARTMENT

NEUROLOGY

DC 54 55 85 F 02
HEAD, SUSAN DIANE
01155 521 EX 11/21/97
[redacted] BL F 3942 DHP
[redacted] A 02
4511 BRYAN ST 01
DALLAS TX 75204

DATE: JUN 24 1997 TIME:	COMMENTS	YES	NO	N/A
Circle if applicable				
Tests, Treatment / Results given to pt.				
Medication / Side Effects				
Discharge: Inst / Referral / Handouts				
Pt. Verbalize: Understanding / Questions / Concerns				
Emergency Precautions				
Pt. Discharge to: Home / Facility				
MD Signature:	Initials:			
RN Signature:	Initials:			

FORM #52350 REV 4/79

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

CONSENTS AND AUTHORIZATIONS

OC 54 55 85 [redacted] 02
HEARN, SUSAN DIANNE
01155-521 CX 11/21/97
[redacted] BL F 3942 DHP
[redacted] ST A C2 C1
DALLAS TX 75204

CONSENT FOR MEDICAL TREATMENT

I do hereby voluntarily consent to and authorize the Dallas County Hospital District (DCHD) to provide care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the attending physician and/or his/her designees. S.H Initials

AUTHORIZATION TO PAY BENEFITS TO DALLAS COUNTY HOSPITAL DISTRICT

I authorize payment directly to the DCHD of all benefits otherwise payable to me or for me by any third party payor. S.H Initials

I understand I am financially responsible to the DCHD for charges not covered by third party payors. S.H Initials

I understand that I shall be billed separately for professional services rendered by each physician or other health care provider. S.H Initials

I hereby authorize DCHD to release any medical information to any third party payor pertaining to my diagnosis and treatment within the DCHD. This may include, but not be limited to, information concerning communicable diseases, laboratory test results, medical history, treatment progress, or any other such related information requested. S.H Initials

I understand that this authorization is valid for the time period which is consistent with the Medical Record Department policy of the DCHD or until the medial claim has been paid, whichever is longer. S.H Initials

AUTHORIZATION TO RELEASE INFORMATION

I authorize DCHD to confirm my presence and release a one word condition statement, such as, "Critical, Serious, Fair, or Good." S.H Initials

I authorize DCHD to release health care information, including medical history, diagnosis, treatment, or prognosis, to my next of kin and/or the following person. List Names S.H Initials

_____

I have read and understand the above consent and authorizations.

Susan Hearn _____ 6/24/97
Signature *(Patient, Guardian, or Legally Authorized Representative)* Date

Relationship to patient _____

DCHD Representative/ID Number DH/3942 Language Assist./ID Number _____

STATEMENT OF PATIENT LEAVING AGAINST MEDICAL ADVICE

I am the responsible party and am removing the patient, _____ from the Dallas County Hospital District and I hereby assume any and all responsibility for accident and illness attending or following the above named patient's discharge from the Dallas County Hospital District. I acknowledge liability for all incurred expenses.

_____ _____
Signature *(Patient, Guardian, or Legally Authorized Representative)* Date

Relationship to patient _____

DCHD Representative/ID Number _____

For DCHD Use Only: _____

_____

E46

PS 845 6/98

PARKLAND HEALTH & HOSPITAL SYSTEM — **PROGRESS NOTES OUTPATIENT DEPARTMENT**

GUARANTOR NAME	GUARANTOR PHONE	MEDICARE NO	MEDICAID NO
INSURANCE COMPANY	GROUP NUMBER	POLICY/CERTIFICATE NO.	CONTRACT NO
NAME OF INSURED	EMPLOYER INSURED		PATIENT PHONE
INSURED EMPLOYER ADDRESS		STATE / ZIP CODE	ACCIDENT RELATED YES ☐ NO ☐

00 54 55 85 A 24
HEARN, SUSAN DIANNE
[illegible] EX 04/30/97
[redacted] BL F 13.84 OHI
[illegible] A 14

DEPT. | PHYSICIAN: Haden | DIAGNOSIS | SERVICE DATE | CASHIER LOCATION | LOCATION | CLINIC CLERK

Date: 5-20-97 Time: 1523 Allergies: No ☑ Yes ☐

V/S T- 98.8 P- 91 RR- 28 B/P- 119/84 (Supine) Wt.- 130 Na Init-

Reason for visit: F/u migraine Last GMC Visit:

Signature: Sheila Martin ID#: 14029 Medications:

36 yo Bg scheduled F/U	① Migraine HA	1 Isometh/Dichlorphen/
Reports some response in HA to Midrin	②④ tobacco	2 1 q 4 hr
Imitrex → N/V ∴ self-D/C'd		3 Propranolol 80 mg
Gets ~ 2-3 HA/wk	MRI 4/4/97	4 1 qd
Sometimes comp. by neuro Sx	unremarkable	5
MRI head NL 4/97		6
		7
CV RRR LAB ∅		8
Chest clear		9
Abd soft		10

New / Dx. / Date

36 yo Bg ♀ severe, freq., complicated migraines	1
	2
→ Refill Midrin	3
→ D/C Propranolol	4

Referrals: D/T will mail 11/97

Next Appointment: 6 MC ♀ HADEN 6 mos

Next lab/x-ray:

MD/NP Signature: WCH ID# 50314

Nurse Signature: HADEN ID#

PS 1088 REV 10/96

PROGRESS NOTES - OUTPATIENT DEPARTMENT

5/20/97 Pharmacy
Rx for Midrin refilled with sig: 2 caps at onset of HA, then 1 cap Q 1 hour until relief or max of 5 caps/12 hours.
Pt. not available for counselling.. Kellie Christopherson, RPh.

5/20/97 4
Rx: Sig used.
K
STAFF 1704

DATE: TIME:	COMMENTS	YES	NO	N/A
Circle if applicable				
Tests, Treatment/Results given to pt.				
Medication/Side Effects				
Discharge: Inst/Referral/Handouts				
Pt. Verbalize: Understanding/Questions/Concerns				
Emergency Precautions				
Pt. Discharge to: Home/Facility				
MD Signature:	Initials:			
RN Signature:	Initials:			

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

CONSENTS AND AUTHORIZATIONS

00 54 55 85 R 24
HEARN, SUSAN DIANNE
[redacted] EX 04/30/97
[redacted] RL F 13284 OHP
[redacted] A 54
[redacted] CH
[redacted] TX 75[redacted]

CONSENT FOR MEDICAL TREATMENT

I do hereby voluntarily consent to and authorize the Dallas County Hospital District (DCHD) to provide care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the attending physician and/or his/her designees. SH Initials

AUTHORIZATION TO PAY BENEFITS TO DALLAS COUNTY HOSPITAL DISTRICT

I authorize payment directly to the DCHD of all benefits otherwise payable to me or for me by any third party payor. SH Initials

I understand I am financially responsible to the DCHD for charges not covered by third party payors. S.H Initials

I understand that I shall be billed separately for professional services rendered by each physician or other health care provider. S.H Initials

I hereby authorize DCHD to release any medical information to any third party payor pertaining to my diagnosis and treatment within the DCHD. This may include, but not be limited to, information concerning communicable diseases, laboratory test results, medical history, treatment progress, or any other such related information requested. S.H Initials

I understand that this authorization is valid for the time period which is consistent with the Medical Record Department policy of the DCHD or until the medial claim has been paid, whichever is longer. SH Initials

AUTHORIZATION TO RELEASE INFORMATION

I authorize DCHD to confirm my presence and release a one word condition statement, such as, "Critical, Serious, Fair, or Good." SH Initials

I authorize DCHD to release health care information, including medical history, diagnosis, treatment, or prognosis, to my next of kin and/or the following person. List Names S.H Initials

_____

I have read and understand the above consent and authorizations.

X Susan Hearn _____ X 5/20/97
Signature *(Patient, Guardian, or Legally Authorized Representative)* Date

Relationship to patient _____

DCHD Representative/ID Number _____ Language Assist./ID Number _____

STATEMENT OF PATIENT LEAVING AGAINST MEDICAL ADVICE
I am the responsible party and am removing the patient, _____ from the Dallas County Hospital District and I hereby assume any and all responsibility for accident and illness attending or following the above named patient's discharge from the Dallas County Hospital District. I acknowledge liability for all incurred expenses.

_____ _____
Signature *(Patient, Guardian, or Legally Authorized Representative)* Date

Relationship to patient _____

DCHD Representative/ID Number _____

For DCHD Use Only: _____

E46

DALLAS COUNTY HOSPITAL DISTRICT 214-827-0177 **PROGRESS NOTES — OUTPATIENT DEPARTMENT**

GUARANTOR NAME PENDING ELIGIBILITY	GUARANTOR PHONE	MEDICARE NO.	MEDICAID NO.
INSURANCE COMPANY	GROUP NUMBER	POLICY/CERTIFICATE NO.	CONTRACT NO. 214-827-0177
NAME OF INSURED	EMPLOYER OF INSURED		PATIENT PHONE X
INSURED EMPLOYER'S ADDRESS MRN # 000000545585 ACC # 000115576217		STATE / ZIP CODE	ACCIDENT RELATED YES ☐ NO ☐
HEARN, SUSAN DIANNE BL F EX 04/30/97 P/C 24 [redacted] 1417 [redacted] DALLAS TX 75204		DEPT. MDB 05/20/97 SERVICE DATE MBH LOCATION	PHYSICIAN DIAGNOSIS CASHIER LOCATION CLINIC CLERK

I GRANT PERMISSION TO THE MEDICAL STAFF OF DALLAS COUNTY HOSPITAL DISTRICT TO PERFORM ANY MEDICAL OR SURGICAL TREATMENT AND TO ADMINISTER SUCH ANESTHETICS AND/OR DRUGS AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND TREATMENT OF SAID PATIENT. FURTHERMORE I STATE THAT THE ABOVE AND FOREGOING FACTS AND INFORMATION ARE TRUE AND CORRECT TO MY PERSONAL KNOWLEDGE.

SIGNATURE

WITNESS

I PROMISE AND AGREE TO PAY PARKLAND MEMORIAL HOSPITAL ALL CHARGES ACCRUING AS A RESULT OF THIS ADMISSION UPON RECEIPT OF STATEMENT. IT IS SPECIFICALLY UNDERSTOOD AND AGREED THAT ALL PAYMENTS WILL BE MADE TO THE BUSINESS OFFICE, PARKLAND MEMORIAL HOSPITAL, 5201 HARRY HINES BLVD., DALLAS, TEXAS; AND

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED HOSPITAL OF THE HOSPITAL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME BUT NOT TO EXCEED THE BALANCE DUE OF THE HOSPITAL'S REGULAR CHARGES FOR THIS PERIOD OF HOSPITALIZATION. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE HOSPITAL FOR THESE CHARGES; AND

I HEREBY AUTHORIZE RELEASE BY THE HOSPITAL OF INFORMATION REQUESTED BY MY INSURANCE COMPANIES.

SIGNATURE

PARKLAND HEALTH & HOSPITAL SYSTEM
Dallas, Texas

AMBULATORY CARE CLINIC

PATIENT CONTACT FORM

Hearn, Susan #545585
Priority

Appointment Date: 03-30-97 Time: 1300

Phone Appointment: Date: ______ Time: ______
F/U ER Migrain Headache
Signature: ______ ID# 0879

Age: 36 Race: B Sex: F

Allergies: NKA

LMP: ____ BTL ____ HYST 1245 Menopause ____

Medical History:
Ø HTN
Ø Cardiac
Ø CA
Ø Seizures ______
X Other Hx Migraine since age 1
Ø DM
Ø Pulm.
Ø Stroke
Ø Infectious Disease

Triage: Date ______ Time ______

Vitals: B/P ____ T ____ P ____ R ____
Size of cuff: *(circle)* Regular Large Pedi
Signature/ID# ______

Appointment Screen: Date 3/30/97 Time 1304

Vitals: B/P 100/60 T 36.6 P 76 R 16
Size of cuff: *(circle)* (Regular) Large Pedi
Signature/ID# ______ RN 6410

Triage Chief Complaint: ______

RN Screening: c/o severe headache ē Rt sided numbness episodes x 1 mo.

Medication(s): ______

Medications (Name, dosage, and frequency)
Propranolol ER 80mg T QD
Midrin T q4hr until relief up to 5 in 12 hrs

Disposition of Patient:
____ **PRIORITY** Appt. ____ Same day Appt.
____ Next Day Appt. ____ Patient to schedule Appt.
____ Referred to: ______

Triage RN Signature: ______
ID#: ______

Module RN Signature: ______ RN
ID#: 6410

TIME	PHYSICIANS ORDERS

Call NO ANSWER				
TIME				
INITIAL				

PS 2118 (Front) 12/96

DALLAS COUNTY HOSPITAL DISTRICT PROGRESS NOTES — OUTPATIENT DEPARTMENT

GUARANTOR NAME	GUARANTOR PHONE	MEDICARE NO.	MEDICAID NO.
HEARN, SUSAN DIANNE	214-827-0177		
INSURANCE COMPANY	**GROUP NUMBER**	**POLICY/CERTIFICATE NO.**	**CONTRACT NO.**
PENDING ELIGIBILITY			
NAME OF INSURED	**EMPLOYER OF INSURED**	**PATIENT PHONE**	
		214-827-0177	
INSURED EMPLOYER'S ADDRESS	**STATE**	**ZIP CODE**	**ACCIDENT RELATED** YES ☐ NO ☐

MRN # 000000545585 ACC # 000115576217 **DEPT.**

HEARN, SUSAN DIANNE BL F EX 04/30/97 SERVICE DATE CLN

F/C 24 [redacted] 1232 LOCATION 03/30/97

[redacted] DALLAS TX 75204 ACC

PHYSICIAN

DIAGNOSIS

CASHIER LOCATION

CLINIC CLERK

36yo. BF c h/o migraine headaches x 23yrs.; pt experiences @ least 1 migraine per week c photophobia. ø N/V. Pt drinks 4-5 cups of coffee/day; (+) smoker. Pt currently having frontal headache c (R) sided numbness; weakness. Pt states propranolol gives her chest heaviness; has not relieved her migraine headaches @ all.

ø PmHx

PE: thin BF wearing sunglasses c lights off

HEENT: H: NCAT PERRLA, EOMI sharp discs B/L

T: (-) erythema (-) exudates; mmm

neck: ø LAD

chest: CTA Bl

CV: rrl $S_1 S_2$ ø M/G/R

neuro: tongue c slight dev. to (L) (R) sided facial numbness, (R) UE numbness LE numbness; MS 4/5 R sided

A/P- Complicated migraine

I GRANT PERMISSION TO THE MEDICAL STAFF OF DALLAS COUNTY HOSPITAL DISTRICT TO PERFORM ANY MEDICAL OR SURGICAL TREATMENT AND TO ADMINISTER SUCH ANESTHETICS AND/OR DRUGS AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND TREATMENT OF SAID PATIENT. FURTHERMORE I STATE THAT THE ABOVE AND FOREGOING FACTS AND INFORMATION ARE TRUE AND CORRECT TO MY PERSONAL KNOWLEDGE.

SIGNATURE

WITNESS

I PROMISE AND AGREE TO PAY PARKLAND MEMORIAL HOSPITAL ALL CHARGES ACCRUING AS A RESULT OF THIS ADMISSION UPON RECEIPT OF STATEMENT. IT IS SPECIFICALLY UNDERSTOOD AND AGREED THAT ALL PAYMENTS WILL BE MADE TO THE BUSINESS OFFICE, PARKLAND MEMORIAL HOSPITAL, 5201 HARRY HINES BLVD., DALLAS, TEXAS; AND

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED HOSPITAL OF THE HOSPITAL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME BUT NOT TO EXCEED THE BALANCE DUE OF THE HOSPITAL'S REGULAR CHARGES FOR THIS PERIOD OF HOSPITALIZATION. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE HOSPITAL FOR THESE CHARGES; AND

I HEREBY AUTHORIZE RELEASE BY THE HOSPITAL OF INFORMATION REQUESTED BY MY INSURANCE COMPANIES

SIGNATURE

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

CONSENTS AND AUTHORIZATIONS

4

CONSENT FOR MEDICAL TREATMENT

I do hereby voluntarily consent to and authorize the Dallas County Hospital District (DCHD) to provide care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the attending physician and/or his/her designees. S.J Initials

AUTHORIZATION TO PAY BENEFITS TO DALLAS COUNTY HOSPITAL DISTRICT

I authorize payment directly to the DCHD of all benefits otherwise payable to me or for me by any third party payor. S.J Initials

I understand I am financially responsible to the DCHD for charges not covered by third party payors. S.J Initials

I understand that I shall be billed separately for professional services rendered by each physician or other health care provider. S.J Initials

I hereby authorize DCHD to release any medical information to any third party payor pertaining to my diagnosis and treatment within the DCHD. This may include, but not be limited to, information concerning communicable diseases, laboratory test results, medical history, treatment progress, or any other such related information requested. S.J Initials

I understand that this authorization is valid for the time period which is consistent with the Medical Record Department policy of the DCHD or until the medial claim has been paid, whichever is longer. S.J Initials

AUTHORIZATION TO RELEASE INFORMATION

I authorize DCHD to confirm my presence and release a one word condition statement, such as, "Critical, Serious, Fair, or Good." S.J Initials

I authorize DCHD to release health care information, including medical history, diagnosis, treatment, or prognosis, to my next of kin and/or the following person. List Names S.J Initials

_____

I have read and understand the above consent and authorizations.

X Susan D. Johnson Heard — Signature *(Patient, Guardian, or Legally Authorized Representative)*

3/30/97 — Date

Relationship to patient _____

DCHD Representative/ID Number RN 13084 Language Assist./ID Number _____

STATEMENT OF PATIENT LEAVING AGAINST MEDICAL ADVICE

I am the responsible party and am removing the patient, _____ from the Dallas County Hospital District and I hereby assume any and all responsibility for accident and illness attending or following the above named patient's discharge from the Dallas County Hospital District. I acknowledge liability for all incurred expenses.

_____ — Signature *(Patient, Guardian, or Legally Authorized Representative)*

_____ — Date

Relationship to patient _____

DCHD Representative/ID Number _____

For DCHD Use Only: _____

E46

PS 845 6/98 **90 Day Trial** *White - Chart* *Yellow - Business Services*

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

OUTPATIENT CLINIC

Discharge & Instruction Progress Note

00 54 55 85 R 24
HEARN, SUSAN DIANNE
0115576217 EX 04/30/97
F 13284 DHP
A 24
01
[redacted]
DALLAS TX 75234

Clinic Name: ACC Date: 3/30/97 Time: 1830
Diagnosis: HA

Treatment, Test, Procedure ☐ YES ☒ N/A If Yes, (Specify):
Consent Forms ☐ YES ☒ N/A If Yes, (Specify):
Medications Documented on Summary List ☐ YES ☒ N/A If Yes, (Specify):
Patients Questions/Concerns Answered ☐ YES ☒ N/A If Yes, (Specify):
Patients Screened for: ☒ Psychosocial ☒ Nutritional ☒ Spiritual ☒ Psychological
Verified Correct Address/Phone ☒ YES (Specify):
Chart Available on Discharge ☐ YES ☑ NO If No, (Specify): N/A
School Work Release ☐ YES ☒ N/A
Chart Check ☐ YES ☒ N/A If Yes, (Date)
Disposition: ☒ Home ☐ Other
Discharge Condition: Ambulatory ☒ Stable ☐ Other (explain)
Discharge With: ☐ Crutches ☐ W/C ☐ Walker ☐ Other (explain)

Unable to Locate Patient for Discharge:

Signature/ID #/Time: Signature/ID #/Time: Signature/ID #/Time:

Please (√) check and list below if applicable
☐ Education Material ☐ Medical Equipment ☐ Labs/Tests
☐ Preprinted Handouts ☑ Medication ☐ Other
☐ Supplies given
Instruction(s) Sumatriptan
Stop Propanolol

Language: *Please* (√) check ☑ English ☐ Spanish ☐ Other *(Specify)*
Community Resources or Referrals Discussed: ☐ YES ☒ N/A If Yes, (Specify):
Patient Needs to Call for Appointment: ☑ YES ☐ NO ☐ N/A
Name of Clinic: MRT (HD) Name of Clinic: Neurology Name of Clinic:
Telephone Number: 590-4500 Telephone Number: Telephone Number:
Health Maintenance Discussed: ☐ YES ☒ NO ☐ N/A If Yes, (Specify):
Follow Up Appointment Given: ☐ YES ☑ NO ☐ N/A If Yes, (Specify below)

Clinic	Clinic	Clinic	Clinic
Date	Date	Date	Date
Time	Time	Time	Time

EMERGENCY PRECAUTIONS / INSTRUCTIONS Return if symptoms worsen
Patient Care Provider Signature Jane Kar MD ID# 1601
Interdisciplinary Team Member Signature ID#
Language Assistant Signature ID#
I have received and understand the instructions given to me.
Patient / Caregiver Susan Dianne Hearn

PS 2149 Revised 11/95/AH White Copy - Chart Yellow Copy - Patient

DALLAS COUNTY HOSPITAL DISTRICT
EMERGENCY DEPARTMENT ADMISSION

ADMIT DATE	ADMIT TIME	ER MD	SERVICE
08/20/97	10:35	10234	4020

PATIENT

NAME (LAST, FIRST, MIDDLE)	MAIDEN	ACCOUNT #	MR #
HEARN, SUSAN DIANNE	ROSS	000115471146	000000545585

ADDRESS	APT#	CITY	STATE	ZIP	COUNTRY
[redacted]		DALLAS	TX	75204 - 6864	057

PHONE	BIRTH DAY	AGE	SEX	RACE	MAR STAT	SOC SEC#	REFERRING PHYSICIAN OR MEDICAL FACILITY	ARR MEANS	CRIME VICTIM	POLICE NOTIF
214-827-0177	[redacted]	036	F	BL	P	[redacted]		SE		

AMBULANCE #	TYPE	LOCATION OF ACCIDENT	ACCIDENT DATE	ACC TIME

EMPLOYER

EMPLOYER	EMPLOYER ADDRESS
DALLAS MORNING NEWS	PLANO PRKWY

EMPLOYER CITY	STATE	ZIP	EMPLOYER PHONE	EXT	WRK REL
PLANO	TX	- 0000	000-000-0000		

GUARANTOR

GUARANTOR'S NAME	GUARANTOR'S ADDRESS	APT. #
HEARN, SUSAN DIANNE	[redacted]	

GUARANTOR'S CITY	STATE	ZIP	PHONE - HOME
DALLAS	TX	75204 - 6864	214-827-0177

GUARANTOR'S EMPLOYER	PHONE - BUSINESS	RELATIONSHIP TO PATIENT
DALLAS MORNING NEWS	000-000-0000	SELF

NEXT OF KIN

NEXT OF KIN	NEXT OF KIN - ADDRESS	PHONE - HOME
JOHNSON, MICHAEL	[redacted]	214-827-0177

NEXT OF KIN - CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	PHONE - BUSINESS
DALLAS	TX	75204 - 6864	HUSBAND	000-000-0000

CONTACT

LOCAL CONTACT	LOCAL CONTACT ADDRESS	PHONE - HOME
SHEPPARD, MARY	[redacted]	214-827-5988

LOCAL CONTACT - CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	PHONE - BUSINESS
DALLAS	TX	75241 - 0000	FRIEND	

INSURANCE

INSURANCE COMPANY	CO/PLN	GROUP NAME	GROUP #	PLAN CODE
TAX SUPPORTED PR	10/001	N / A	N / A	N/A

EFFECTIVE DATE	NAME OF INSURED	I.D. #	AUTHORIZATION #	CERT DATE
/ /	HEARN, SUSAN DIANN		N / A	

DX

PROBLEM/CHIEF COMPLAINT	COND	S1	S2	S3	LAST DC DATE	FNI CLS	ADM BY
HEADACHE	2	A				10	LER

CONSENT FOR TREATMENT/RELEASE OF RESPONSIBILITY FOR VALUABLES

I grant permission to the medical staff of the Dallas County Hospital District to perform any medical or surgical treatment and to administer such anesthestics and/or drugs as may be deemed necessary in the diagnosis and treatment of said patient. Futhermore I state that all patient information is true and correct to my personal knowledge, I also release the Dallas County Hospital District from all responsibility for any valuables and personal articles that are not checked in by the hospital staff.

SIGNED: _____ RELATIONSHIP IF OTHER THAN PATIENT IS SIGNING: _____

WITNESS: _____ TIME: _____

LEAVING AGAINST MEDICAL ADVISE

I am the responsible party and am removing the patient, _____, from the Dallas County Hospital District and I hereby assume any and all responsibility for accident and illness attending or following the above named patient's discharge from the above named institution. I acknowledge liability for all incurred expenses, including all Emergency Room fees.

SIGNED: _____ RELATIONSHIP IF A MINOR: _____

MD SIGNATURE: _____ DATE: _____ TIME: _____

TEMPORARY ABSENCE RELEASE

I have obtained permission from the attending physician to be absent from the Emergency Dept. for my convenience from:

TIME: _____ DATE: _____ to TIME: _____ DATE: _____

I assume all responsibility for the named patient, during this temporary absence and hereby release the Dallas County Hospital District, its employees and the attending physician from all responsibility during this absence and for my or the patient's condition as a result thereof.

SIGNED: MP RELATIONSHIP IF A MINOR: _____

MD SIGNATURE: 3/21 / 346.90 DATE: _____ TIME: _____

FORM 580002 REV 12/91

O: I: E:

MEDICAL RECORD

ADMIT DATE	ADMIT TIME	DALLAS COUNTY HOSPITAL DISTRICT EMERGENCY DEPARTMENT ADMISSION	ER MD	SERVICE
03/20/97	10:35		10234	4020

PATIENT

NAME LAST	FIRST	MIDDLE	MAIDEN	ACCOUNT #	MR #
HEARN,	SUSAN	DIANNE	ROSS	000115471146	000000545585

ADDRESS	APT#	CITY	STATE	ZIP	COUNTRY
4511 BRYAN ST		DALLAS	TX	75204 - 6864	057

PHONE	BIRTH DAY	AGE	SEX	RACE	MAR STAT	SOC SEC#	REFERRING PHYSICIAN OR MEDICAL FACILITY	ARR MEANS	CRIME VICTIM	POLICE NOTIF
214-827-0177	[redacted]	036	F	BL	P	[redacted]		SE		

AMBULANCE #	TYPE	LOCATION OF ACCIDENT	ACCIDENT DATE	ACC TIME

EMPLOYER

EMPLOYER	EMPLOYER ADDRESS
DALLAS MORNING NEWS	PLANO PRKWY

EMPLOYER CITY	STATE	ZIP	EMPLOYER PHONE	EXT	WRK REL
PLANO	TX	- 0000	000-000-0000		

GUARANTOR

GUARANTOR'S NAME	GUARANTOR'S ADDRESS	APT. #
HEARN, SUSAN DIANNE	[redacted]	

GUARANTOR'S CITY	STATE	ZIP	PHONE - HOME
DALLAS	TX	75204 - 6864	214-827-0177

GUARANTOR'S EMPLOYER	PHONE - BUSINESS	RELATIONSHIP TO PATIENT
DALLAS MORNING NEWS	000-000-0000	SELF

NEXT OF KIN

NEXT OF KIN	NEXT OF KIN - ADDRESS	PHONE - HOME
JOHNSON, MICHAEL	[redacted]	214-827-0177

NEXT OF KIN - CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	PHONE - BUSINESS
DALLAS	TX	75204 - 6864	HUSBAND	000-000-0000

CONTACT

LOCAL CONTACT	LOCAL CONTACT ADDRESS	PHONE - HOME
SHEPPARD, MARY	[redacted]	214-827-5988

LOCAL CONTACT - CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	PHONE - BUSINESS
DALLAS	TX	75241 - 0000	FRIEND	

INSURANCE

INSURANCE COMPANY	CO/PLN	GROUP NAME	GROUP #	PLAN CODE
TAX SUPPORTED PR	10/001	N / A	N / A	N/A

EFFECTIVE DATE	NAME OF INSURED	I.D. #	AUTHORIZATION #	CERT DATE
/ /	HEARN, SUSAN DIANN		N / A	

DX

PROBLEM/CHIEF COMPLAINT	COND	S1	S2	S3	LAST DC DATE	FNI CLS	ADM BY
HEADACHE	2	A				10	LER

CONSENT FOR TREATMENT/RELEASE OF RESPONSIBILITY FOR VALUABLES

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SIGNED: _____ RELATIONSHIP IF OTHER THAN PATIENT IS SIGNING: _____

WITNESS: _____ TIME: _____

LEAVING AGAINST MEDICAL ADVISE

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SIGNED: _____ RELATIONSHIP IF A MINOR: _____

MD SIGNATURE: _____ DATE: _____ TIME: _____

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

DEPARTMENT OF EMERGENCY SERVICES
PHYSICIAN REPORT

00 54 55 95 5 10
HEARN, SUSAN DIANNE
011-471146 AD 03/20/97
[redacted] F 1848 4020
A 10
10234

ALLERGIES: NKA

INITIAL VITAL SIGNS TIME: 0958 T 36.7 P 88 R 24 BP 132/86

COMPLAINT: HEADACHE

PHYSICIAN NOTES | TIME SEEN: 1000

HISTORY / HEENT / NECK / CHEST:
36 y.o. BF c̄ PMH of migraine HA's since age 12 presents c̄ HA, photophobia, preceded by N/V since 10pm last night. Pt seen in ER 2wks ago for migraine & given propranolol prophylaxis. Feels it has been working, but ran out. Took 2 midrin last night near the onset of the HA, then several hrs later, took 1 more, and took 1 this AM. Denies F/C/neck stiffness. Husband denies any confusion, disorientation. Entire episode preceded by hand tingling — her typical symptom. Has no cardiac hx, ∅ h/o CP, SOB, rxns to Rx — ∅ contraindications to [illegible].
PMH ∅ x migraine. Meds — midrin prn, propranolol. ALL ∅. SH — ⊕ tobacco.

HEART / ABD. / EXT. / NEURO:
PE — Young BF, obviously photophobic, hesitant to move.
HEENT — ∅ trauma. Fundoscopic exam difficult, but discs sharp.
Neck — supple, full ROM.
CV — RRR ∅ M/R/G. Lungs — CTA and.
Abd — soft NT. ∅ HSM. Neuro — difficult exam. ∅ focal findings. A/Ox3.

A/P — classic migraine which responded previously to propranolol prophylaxis. Will give midrin II tabs, then q hr. Also IM compazine. Will re-assess in 1 hr.

VASCULAR

☐ SEE CONT. SHEET

LAB/RADIOLOGY ORDERS (CIRCLE)

CBC-DIFF	UA	GLU	CREAT
PT—PTT	ABG	RPR	TOX
CARDIAC ENZYMES	LIVER BATTERY		
CA	MG	PO4	I&C:
ETOH	AMYLASE	G&S	
LYTES, BUN, EKG			
OTHER:			
X RAY:			

TIME	ORDERS
	midrin, II tabs PO x1
	compazine, 10mg IM — done
	~~midrin, I tab PO x1~~ done

CONSULT/ADMIT SERVICES

SERVICE	TIME CALLED	TIME IN DEPT.

DIAGNOSIS: Migraine.

DIAGNOSIS CODE:

MD SIGNATURE: [signature], MD

MD PRINTED NAME: HAGEN

FACULTY SIGNATURE:

DISCHARGE PLAN / RX GIVEN / FOLLOW-UP
(1) D/C home
(2) Take midrin exactly as directed
(3) Take propranolol daily
(4) F/u ACC for refills
(5) F/u Clinic as scheduled.

DISPOSITION: ☐ HOME ☐ AMA ☐ AWOL ☐ ADMIT (SERVICE: ______) TRANSFER TO: ______

CONDITION: ☐ IMPROVED ☐ UNCHANGED ☐ EXPIRED TIME ______ AM/PM DATE: ______

005

55690 Revised 12/91

MEDICAL RECORDS

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

CONSENTS AND AUTHORIZATIONS

HEARN, SUSAN DIANNE
AD 03/20/97
[redacted]
F 1848 4020
A 10
01

CONSENT FOR MEDICAL TREATMENT

I do hereby voluntarily consent to and authorize the Dallas County Hospital District (DCHD) to provide care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the attending physician and/or his/her designees. SH Initials

AUTHORIZATION TO PAY BENEFITS TO DALLAS COUNTY HOSPITAL DISTRICT

I authorize payment directly to the DCHD of all benefits otherwise payable to me or for me by any third party payor. Initials

I understand I am financially responsible to the DCHD for charges not covered by third party payors. Initials

I understand that I shall be billed separately for professional services rendered by each physician or other health care provider. Initials

I hereby authorize DCHD to release any medical information to any third party payor pertaining to my diagnosis and treatment within the DCHD. This may include, but not be limited to, information concerning communicable diseases, laboratory test results, medical history, treatment progress, or any other such related information requested. Initials

I understand that this authorization is valid for the time period which is consistent with the Medical Record Department policy of the DCHD or until the med l :laim has been paid, whichever is longer. Initials

AUTHORIZATION TO RELEASE INFORMATION

I authorize DCHD to confirm my presence and release a one word condition statement, such as, "Critical, Serious, Fair, or Good." Initials

I authorize DCHD to release health care information, including medical history, diagnosis, treatment, or prognosis, to my next of kin and/or the following person. List Names Initials

_____

I have read and understand the above consent and authorizations.

Susan D Hearn 3/20/97

Signature *(Patient, Guardian, or Legally Authorized Representative)* Date

Relationship to patient _____

DCHD Representative/ID Number R. Redwine 98 Language Assist./ID Number _____

STATEMENT OF PATIENT LEAVING AGAINST MEDICAL ADVICE

I am the responsible party and am removing the patient, _____ from the Dallas County Hospital District and I hereby assume any and all responsibility for accident and illness attending or following the above named patient's discharge from the Dallas County Hospital District. I acknowledge liability for all incurred expenses.

_____ _____

Signature *(Patient, Guardian, or Legally Authorized Representative)* Date

Relationship to patient _____

DCHD Representative/ID Number _____

For DCHD Use Only: _____

_____

E46

PS 845 6/96

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

EMERGENCY SERVICES DEPARTMEN[redacted]
MEDICINE PATIENT ASSESSMENT FORM

93 54 55 85 = 10
HEARN, SUSAN DIANNE
011 4.7 1146 AD 03/20/97
[redacted] F 1848 4030
A 10
01
Hearn

INITIAL ASSESSMENT TIME: 1005 DATE: 3-20-97 ARRIVED: AMBULATORY ✓ NON-AMBULATORY ______

ALLERGIES: NKDA

CHIEF COMPLAINT: Headache c̄ (R) side numb.

LEVEL OF CARE (circle) 1 (2) 3 4 5

NURSING ASSESSMENT: 26 yo BF presents amb. to ESD c̄ above complaint x 2 days. Pt. reports sudden onset of sharp headache pain all over head. Reports (+) blurry vision & (+) photophobia. (+) nausea & vomiting. A1Ox3. Resp. even & non-labored. Skin warm & dry. Gait steady. Pt. very tearful.

VITAL SIGNS

TIME	B/P	TEMP	PULSE	RESP/O_2SAT	D-STIX	INIT.
0958	132/86	36.7	88	24		RP
1150	128/86	37°	92	22		K
1440	130/86	36.5	64	16		K

PATIENT VALUABLES / BELONGINGS

With Patient ______ With Family ______ Cashier ______

IMMUNIZATIONS REVIEWED: YES ______ NO ______ N/A ______

IMMUNIZATION REFERRAL SHEET GIVEN: YES ______ NO ______

MEDICAL HISTORY (+) YES (-) NO

—	CARDIAC	—	HTN
—	COPD/ASTHMA	—	RENAL
—	DIABETES	—	IDP
—	SEIZURE DISORDER	—	OTHER (describe)

PATIENT REFERRALS

TYPE:

INTAKE

TIME	#IV	SITE	GAUGE	TYPE FLUID	VOLUME/ TOTAL	INIT.

CURRENT MEDICATIONS

isometh/dichlor/acet cmpd
propranolol

INTAKE

TIME	TYPE	VOLUME/TOTAL	INIT

PATIENT RESPONSE

PREGNANT: ☐ YES ☑ NO ☐ UNK ☐ N/A 1024

SIGNATURE / ID # [signature] RN

MEDICATIONS ADMINISTERED

DRUG	DOSAGE	ROUTE/ SITE	TIME	PLUG FLUSHED	INIT.
Midrin	ii	po	1220	/	K
Compazine	10mg	IM (R) delt	1220	/	K
Midrin	i	PO	1330	—	[initials]
Midrin	i	po	1430	—	K

RN / LVN / PCT
INITIALS / ID # K / ID # 10532 ______ / ID # ______ / ID # ______ / ID # ______

SIGNATURE: Krista Costilow

006

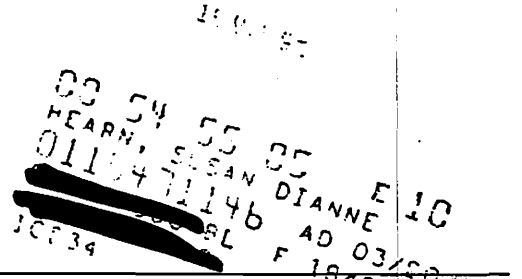
PS 599 Rev. 7/95 White Copy - Chart Yellow Copy - Faculty Pink Copy - Management

DALLAS COUNTY HOSPITAL DISTRICT

DALLAS, TEXAS

EMERGENCY ROOM RECORD

CONTINUATION



NAME: Last First Middle

Emergency Room Number: Date 01/10

Time Ordered	Medications and Treatments (continued)
1150	pt placed in #23 A, AEOX3, resp even/ non-labored. C/O severe HA ĉ blurry vision & photophobia. placed in #23 Awaiting M.D. eval. pt states seen ~2 week ago for migraine HA & given Propranolol. pt out of med. verbalized relief while using it. pt has neuro f/u 3/30/97. —Krista Costilow
1220	pt med as ordered, awaiting M.D. eval-Krista Costilow
1430	pt given 3rd dose midrin ĩ tabs po. Dr. Aergen gave pt 2nd dose @ 1320. pt verbalizes relief from midrin Compazine, awaiting further M.D. eval—Krista Costilow
1535	D'cd home A, AEOX3, resp even/ non-labored Verbalized understanding of all instructions, left ambulatory, gait steady to appt desk-Kcostilow

006

FORM NO. 55090 (REV. 2/77)

MEDICAL RECORDS

DALLAS COUNTY HOSPITAL DISTRICT

DALLAS, TEXAS

EMERGENCY ROOM RECORD

CONTINUATION

00 54 55 85 E 10
HEARN, SUSAN DIANNE
0115 [illegible]
[redacted]
10234
03/20/97 4020

NAME: Last	First	Middle	
Emergency Room Number:		Date	

Time Ordered	Medications and Treatments (continued)
1130	pt placed in #23 A, ABCs, resp even/unlabored.
	c/o severe HA c nausea & photophobia [illegible]
	#23 Awaiting M.D. eval pt states seen ~ 2 week ago
	for migraine HA & given Propranolol pt out of med.
	verbalizes relief while using it. pt has neuro f/u
	3/20/97. ——— Krista Costillon
1220	pt med as ordered, awaiting M.D eval - Krista Costillon
1430	pt given 3rd dose med [illegible] in triage care
	pt 2nd dose @ 1330. pt verbalizes relief from meds &
	Compazine, awaiting further M.D. eval - Krista Costillon
[illegible]	D/c'd [illegible] ABCs, resp even unlabored.
	Verbalizes understanding of all instructions. pt left
	ambulatory, [illegible] to [illegible] - Krista Costillon

006

FORM NO. 55090 (REV. 2/77)

DATA ENTRY

INPATIENT—FILE WITH ADMINISTRATIVE RECORDS ON FRONT CLIP

DALLAS COUNTY HOSPITAL DISTRICT

DALLAS, TEXAS

00 54 55 85 E 10
HEARN, SUSAN DIANNE
211547114h AD 03/20/97
[redacted] F 1-4P 4020
A 10
C1

WORK/SCHOOL RELEASE AND APPOINTMENT VERIFICATION

APPOINTMENT VERIFICATION

This is to indicate that Susan Hearn

has been seen in the Medicine ER of Dallas County
(TREATMENT AREA)

Hospital District on 3/20/97
(DATE)

Krista Costilow RN
PRINTED NAME

Krista Costilow RN
SIGNATURE

Date: 3/20/97

MEDICAL RELEASE/RESTRICTIONS

This patient is considered ready to return to work/school on _____

_____ MD
PRINTED NAME

_____ MD
SIGNATURE

Date: _____

OUTPATIENT—FILE BEHIND SOCIAL HISTORY RECORDS ON FRONT CLIP

N35

FORM NO. 52820 (REV. 9/87) WHITE COPY – CHART YELLOW COPY – PATIENT

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

HEARN, SUSAN DIANNE AD 03/30/
[redacted] F 1648 A 10 01
10234

DEPARTMENT OF EMERGENCY SERVICES
AFTER CARE INSTRUCTIONS

IMPORTANT: We have examined and treated you today on an emergency basis only. This is not a substitute for, or an effort to provide complete medical care. In most cases you must let your private doctor check you again. If you have been referred to a clinic, we strongly recommend that you keep your appointment. If you have had special tests such as EKG's, X-rays or labs we will review them again. We will attempt to call you if there are any suggestions. After leaving, follow the instructions listed below.

DIAGNOSIS: Migraine Headache

MEDICATION:
FOLLOW LABEL INSTRUCTIONS FOR ANY PRESCRIPTION GIVEN BY EMERGENCY PHYSICIAN
☐ TAKE ANTIBIOTICS UNTIL GONE

PREPRINTED INSTRUCTIONS GIVEN: ☐ YES ☐ N/A
IN SPANISH: ☐ YES ☐ N/A

☐ BACTRIM	☐ PENICILLIN
☐ CLOTRIMAZOLE VAGINAL CREAM/TAB	☐ PHENOBARBITAL
☐ DOXYCYCLINE	☐ PREDNISONE
☐ DILANTIN	☐ TETRACYCLINE
☐ ERYTHROMYCIN	☐ TYLENOL #3
☐ IBUPROFEN/MOTRIN	☐ VERAPAMIL
☐ FLAGYL	☐ ZANTAC
☐ KEFLEX	☑ Midrin
☐ LASIX	☑ Propranolol
☐ ROBAXIN	☐

DEMONSTRATED/PREPRINTED INSTRUCTIONS GIVEN
☐ ABDOMINAL WARNINGS
☐ BURN CARE
☐ CAST CARE
☐ CRUTCH TRAINING
☐ D&C FOLLOW-UP
☐ DRESSING CHANGE
☐ FOOT CARE
☐ HEAD INJURY
☐ SUTURE CARE
☐ WOUND CARE
☐ WET TO DRY DRESSING
☐ OTHER _____

OTHER RESOURCES
☐ DENTAL CLINIC REFERRAL
☐ HEALTH DEPT. REFERRAL
☐ HOMELESS REFERRAL
☐ SOCIAL SERVICES REFERRAL
☐ FAMILY PLANNING REFERRAL

SPECIAL INSTRUCTIONS: ① Take Midrin exactly as directed - take all medications as directed ② Follow up in Acc Clinic. when medication running low ③ Follow up in General Medicine Clinic as scheduled ④ Return to ER for return of headache, nausea/vomiting Temperature >101°F, neck pain or any problems

FOLLOW-UP/CLINIC APPOINTMENT GIVEN: ☑ YES ☐ N/A **PRESCRIPTION GIVEN:** ☑ YES ☐ N/A

I HAVE RECEIVED AND UNDERSTAND THE INSTRUCTIONS ABOVE. I UNDERSTAND THAT I HAVE HAD EMERGENCY TREATMENT ONLY. I WILL ARRANGE FOR FOLLOW-UP CARE AS INSTRUCTED AND I WILL CAREFULLY FOLLOW THE INSTRUCTIONS GIVEN.

TRANSLATOR USED: ☐ YES ☑ N/A

DISCHARGED: ☑ HOME ☐ OTHER _____ (X) Susan Hearn
PATIENT/SIGNIFICANT OTHER SIGNATURE

☐ AMBULATORY ☑ WHEELCHAIR ☐ OTHER _____

RN/MD SIGNATURE: Cynthia Coffman 10532 DATE: 3/20/97 TIME: 1535

UNAVAILABLE FOR DISCHARGE TEACHING: 1) _____ TIME/INITIAL 2) _____ TIME/INITIAL 3) _____ TIME/INITIAL

006A

PS 149 Revised 9/92 White Copy - Medical Record Yellow Copy - Patient's Copy

DALLAS COUNTY HOSPITAL DISTRICT
EMERGENCY DEPARTMENT ADMISSION

ADMIT DATE	ADMIT TIME	ER MD	SERVICE
03/03/97	11:07	10270	4020

PATIENT

NAME (LAST, FIRST, MIDDLE)	MAIDEN	ACCOUNT #	MR #
HEARN, SUSAN DIANNE	ROSS	000115270498	000000545585

ADDRESS	APT #	CITY	STATE	ZIP	COUNTRY
[redacted]		DALLAS	TX	75204 - 6738	057

PHONE	BIRTH DAY	AGE	SEX	RACE	MAR STAT	SOC SEC #	REFERRING PHYSICIAN OR MEDICAL FACILITY	ARR MEANS	CRIME VICTIM	POLICE NOTIF
214-827-5988	[redacted]	036	F	BL	P	[redacted]		AM		

AMBULANCE #	TYPE	LOCATION OF ACCIDENT	ACCIDENT DATE	ACC TIME
DFD702				

EMPLOYER

EMPLOYER	EMPLOYER ADDRESS
NONE	

EMPLOYER CITY	STATE	ZIP	EMPLOYER PHONE	EXT	WRK REL
		- 0000			

GUARANTOR

GUARANTOR'S NAME	GUARANTOR'S ADDRESS	APT. #
HEARN, SUSAN DIANNE	[redacted]	

GUARANTOR'S CITY	STATE	ZIP	PHONE - HOME
DALLAS	TX	75204 - 6738	214-827-5988

GUARANTOR'S EMPLOYER	PHONE - BUSINESS	RELATIONSHIP TO PATIENT
NONE		SELF

NEXT OF KIN

NEXT OF KIN	NEXT OF KIN - ADDRESS	PHONE - HOME
SHEPPARD, MARY	[redacted]	214-827-5988

NEXT OF KIN - CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	PHONE - BUSINESS
DALLAS	TX	75241 - 0000	FRIEND	000-000-0000

CONTACT

LOCAL CONTACT	LOCAL CONTACT ADDRESS	PHONE - HOME
SHEPPARD, MARY	[redacted]	214-827-5988

LOCAL CONTACT CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	PHONE - BUSINESS
DALLAS	TX	75241 - 0000	FRIEND	

INSURANCE

INSURANCE COMPANY	CO/PLN	GROUP NAME	GROUP #	PLAN CODE
TAX SUPPORTED PR	10/001	N / A	N / A	N/A

EFFECTIVE DATE	NAME OF INSURED	I.D. #	AUTHORIZATION #	CERT DATE
/ /	HEARN, SUSAN DIANN		N / A	

DX

PROBLEM/CHIEF COMPLAINT	COND	S1	S2	S3	LAST DC DATE	FNI CLS	ADM BY
HEADACHE	2	A				10	ST

CONSENT FOR TREATMENT/RELEASE OF RESPONSIBILITY FOR VALUABLES

I grant permission to the medical staff of the Dallas County Hospital District to perform any medical or surgical treatment and to administer such anesthestics and/or drugs as may be deemed necessary in the diagnosis and treatment of said patient. Futhermore I state that all patient information is true and correct to my personal knowledge, I also release the Dallas County Hospital District from all responsibility for any valuables and personal articles that are not checked in by the hospital staff.

SIGNED: _____ RELATIONSHIP IF OTHER THAN PATIENT IS SIGNING: _____

WITNESS: 346.90 TIME: _____

LEAVING AGAINST MEDICAL ADVISE

I am the responsible party and am removing the patient, _____, from the Dallas County Hospital District and I hereby assume any and all responsibility for accident and illness attending or following the above named patient's discharge from the above named institution. I acknowledge liability for all incurred expenses, including all Emergency Room fees.

SIGNED: _____ RELATIONSHIP IF A MINOR: _____

MD SIGNATURE: _____ DATE: _____ TIME: _____

TEMPORARY ABSENCE RELEASE

I have obtained permission from the attending physician to be absent from the Emergency Dept. for my convenience from:

TIME: _____ DATE: _____ to TIME: _____ DATE: _____

I assume all responsibility for the named patient, during this temporary absence and hereby release the Dallas County Hospital District, its employees and the attending physician from all responsibility during this absence and for my or the patient's condition as a result thereof.

SIGNED: _____ RELATIONSHIP IF A MINOR: _____

MD SIGNATURE: _____ DATE: _____ TIME: _____

FORM 580002 REV 12/91

O: I: E:

MEDICAL RECORD

26

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

DEPARTMENT OF EMERGENCY SERVICES
PHYSICIAN REPORT

00 54 55 85 E 10
HEAGN, SUSAN DIANNE
[redacted] AD 03/03/97
F 11035 4080
A 10
01

ALLERGIES: NKDA

INITIAL VITAL SIGNS TIME: 1100 T 37.3 P 84 R 22 BP 121/77

COMPLAINT: MIGRAINE H/A.

PHYSICIAN NOTES TIME SEEN: _____

HISTORY
36 YO BF C 2d YR H2 of migraine H/A in for migraine H/A starting 5 hours ago. Pt took midrin x 2 @ onset 5 relief. Pt had [redacted] of (B) sided numbness that usually lasts <30 minutes and progresses to mild tingling → normal. Pt claims nausea 5 vomiting. Pt has had >5 ED visits in last 12 months for H/A and >10 @ home that she stayed @ home for.

HEENT
(2) Eyes PERRLA. Pt exhibits EOM I.
Ears EAC clear. TM's intact.
Nose - Patent. Ø septal deviation noted.
Throat - mild pharyngeal swelling noted 5 exudate or exudate.

NECK
Chest - Soft mildly tender (L) lateral lymph nodes
Chest - CTA (B)

HEART
CV - RRR 5 M/R/G
Abd - Soft/NT/NOS Ø organomegaly noted.

EXT.
Ext - Warm + dry. Capillary refill <3 sec.

NEURO.
Neuro - A+O x 3. Decreased sensation to light touch. sharp/dull decreased in (L) ½ of body.

VASCULAR
OTR + 2/4 throughout

☐ SEE CONT. SHEET

LAB/RADIOLOGY ORDERS (CIRCLE)

CBC-DIFF UA GLU CREAT
PT—PTT ABG RPR TOX
CARDIAC ENZYMES LIVER BATTERY
CA MG PO4 I&C: _____
ETOH AMYLASE G&S
LYTES, BUN, EKG
OTHER: _____
X RAY: _____

TIME	ORDERS
1130	Midrin #1 PO now
1335	~~Tylenol #3 tab po x now pt refused~~
1400	~~Phenergan~~ Tylenol #3 tab po x now pt refused

CONSULT/ADMIT SERVICES

SERVICE	TIME CALLED	TIME IN DEPT.

DIAGNOSIS: Migraine Headache
DIAGNOSIS CODE:

DISCHARGE PLAN / RX GIVEN / FOLLOW-UP
Midrin Tr PO @ onset H/A then 1 PO Q8° up to 5/12°
Inderal 20mg PO QDH for Prophylaxis. F/U Acc
3/30/97 for Inderal refill (Not available)
Neurology = DR KOTAN. RETURN TO ACC
or ED if Sx return.

MD SIGNATURE: DR Burns PGY-3 CWallyM
MD PRINTED NAME: DR Burns PGY-3 CWallyM
FACULTY SIGNATURE:

DISPOSITION: ☐ HOME ☐ AMA ☐ AWOL ☐ ADMIT (SERVICE: _____) TRANSFER TO: _____
CONDITION: ☐ IMPROVED ☐ UNCHANGED ☐ EXPIRED TIME _____ AM PM DATE: _____

005

55890 Revised 12/91

MEDICAL RECORDS

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

EMERGENCY SERVICES DEPARTMENT
MEDICINE PATIENT ASSESSMENT FORM

~~Johnson~~ Hearn

INITIAL ASSESSMENT TIME: 1105 DATE: 3/2/97 ARRIVED: AMBULATORY ______ NON-AMBULATORY X

ALLERGIES: NKDA

CHIEF COMPLAINT: "Migraine"

LEVEL OF CARE (circle) 1 2 3 4 5

NURSING ASSESSMENT: 36 y/o BF c Hx migraines presents to ER via ambulance c/o severe HA all over starting this am c numbness on (R) side of body. c/o photophobia, nausea & emesis crying c slow deliberate speech. AAOx3 skin W/D MAE even unlabored.

VITAL SIGNS

TIME	B/P	TEMP	PULSE	RESP/O_2SAT	D-STIX	INIT.
1100	121/77	37.3	84	22		[illegible]
1500	138/99	37.2	82	20		JM

PATIENT VALUABLES / BELONGINGS

With Patient ______ With Family ______ Cashier ______

IMMUNIZATIONS REVIEWED: YES ______ NO ______ N/A ______

IMMUNIZATION REFERRAL SHEET GIVEN: YES ______ NO ______

MEDICAL HISTORY (+) YES (-) NO

Ø	CARDIAC		HTN
	COPD/ASTHMA		RENAL
	DIABETES		IDP
	SEIZURE DISORDER	✓	OTHER (describe) migraines

PATIENT REFERRALS

TYPE:

INTAKE

TIME	#IV	SITE	GAUGE	TYPE FLUID	VOLUME/ TOTAL	INIT.

CURRENT MEDICATIONS

Midrin

INTAKE

TIME	TYPE	VOLUME/TOTAL	INIT.

PATIENT RESPONSE

1300 mild relief from midrin [illegible]

PREGNANT: ☐ YES ☐ NO ☐ UNK ☐ N/A

SIGNATURE/ID #: JMullinax #[illegible]

MEDICATIONS ADMINISTERED

DRUG	DOSAGE	ROUTE/ SITE	TIME	PLUG FLUSHED	INIT.
midrin	#2	PO	1205	NA	DK
Midrin	T	PO	1400	JM	

RN / LVN / PCT INITIALS / ID #: DK / ID # 13679 JM / ID # [illegible] ______ / ID # ______ / ID #

SIGNATURE: Deborah Klusa JMullinax

006

PS 599 Rev. 7/95 White Copy - Chart Yellow Copy - Faculty Pink Copy - Management

DALLAS COUNTY HOSPITAL DISTRICT

DALLAS, TEXAS

EMERGENCY ROOM RECORD

CONTINUATION

NAME: Last First Middle

Emergency Room Number: Date

Time Ordered	Medications and Treatments (continued)
1155	pt moved from M to room 26 — [illegible]
1205	MD at BS performing [illegible] Midrin #1
	administered — [illegible]
1500	pt. states "I feel much better" family @
	bedside. [illegible] to home c written instructions
	verbalized understanding [illegible]
	even unlabored — [illegible]

006

FORM NO. 55090 (REV. 2/77)

MEDICAL RECORDS

ADMIT DATE	ADMIT TIME
03/03/97	11:07

DALLAS COUNTY HOSPITAL DISTRICT
EMERGENCY DEPARTMENT ADMISSION

ER MD	SERVICE
10270	4020

PATIENT

NAME (LAST, FIRST)	MIDDLE	MAIDEN	ACCOUNT #	MR #
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AMBULANCE #	TYPE	LOCATION OF ACCIDENT	ACCIDENT DATE	ACC TIME
DFD702				

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EMPLOYER	EMPLOYER ADDRESS
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EMPLOYER CITY	STATE	ZIP	EMPLOYER PHONE	EXT	WRK REL
		- 0000			

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NEXT OF KIN

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DX

PROBLEM/CHIEF COMPLAINT	COND	S1	S2	S3	LAST DC DATE	FNI CLS	ADM BY
HEADACHE	2	A				10	ST

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SIGNED: _____ RELATIONSHIP IF A MINOR: _____

MD SIGNATURE: _____ DATE: _____ TIME: _____

DALLAS FIRE DEPARTMENT EMERGENCY MEDICAL SERVICES — **PATIENT FORM**

OVERLOAD-Y ☐ N ☐

Patient No. 1 of ___ Date 3-9-12 Time 1022 Incident # 21073

Location [redacted] Apt/Suite # 201

Patient Name Susan Dianne Hearn

Responsible Adult ___ Relation ___

Patient Address SAME

City ___ State ___ Zip Code 75204 Phone # ___ Homeless ☐ Y ☒ N

Medicare/caid # ___ Race ___ Sex ___

Social Security # ___ DOB 6/14/60 Age ___

Chief Complaint/Present History [illegible] - Migraine

1st set of Vital Signs: B/P [illegible] P [illegible] R 14 @ 1024

2nd set of Vital Signs: B/P ___ P ___ R ___ @ ___

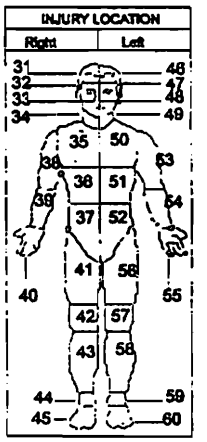
Tilt Test: B/P ___ P ___ +or- ___ @ ___

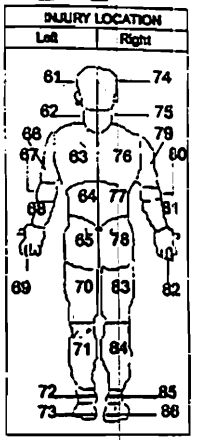
Temperature ___ D-Stick ___

Past History [illegible]

Patient Medication [illegible]

Allergies NKA





TRAUMA ASSESSMENT

1 ☐ abrasions	8 ☐ edema	15 ☐ fx/spine
2 ☐ amputation	9 ☐ evisceration	16 ☐ hematoma
3 ☐ avulsion	10 ☐ flail chest	17 ☐ laceration
4 ☐ battle signs	11 ☐ fx/angulated	18 ☐ penetrating
5 ☐ blunt	12 ☐ fx/closed	19 ☐ targeting
6 ☐ contusion	13 ☐ fx/depressed	20 ☐ dislocation
7 ☐ no distal pulse	14 ☐ fx/open	21 ☐ sprain/strain

PATIENT ASSESSMENT (check all that apply)

RESPIRATIONS
1 ☒ clear
2 ☐ decreased-right
3 ☐ decreased-left
4 ☐ rales
5 ☐ wheezes
6 ☐ dyspnea
7 ☒ labored
8 ☐ apnea
9 ☐ shallow
10 ☐ hypervent.

NEUROLOGICAL
1 ☒ awake/alert
2 ☐ disoriented
☐ responds to:
3 ☐ sound 4 ☐ pain
5 ☐ unconscious
6 ☐ normal motor
☐ decreased motor

PUPILS
1 ☒ reactive
2 ☐ nonreactive
3 ☐ dilated-right
4 ☐ dilated-left
5 ☐ constricted
6 ☐ irregular

SIGNAL 27
1 ☐ dep. lividity
2 ☐ decapitation
3 ☐ decomposition
4 ☐ rigor mortis
5 ☐ trauma H
6 ☒ trauma B
7 ☐ DNR arm band
Number ___

SKIN
1 ☒ normal
2 ☐ diaphoretic
3 ☐ pale
4 ☐ cyanny
5 ☒ hot/warm
6 ☐ dry
7 ☐ cyanotic

BLEEDING
1 ☐ arterial
2 ☐ venous
3 ☒ minimal
4 ☐ moderate
5 ☐ severe

CARDIAC
1 ☐ pain-right
2 ☐ pain-left
3 ☐ mid-sternum
4 ☒ radiates
5 ☐ relieved/Nitro
6 ☐ edema

BURN
1 ☐ thermal
2 ☐ chemical
3 ☒ electrical
4 ☐ 2° ___ %
5 ☐ 3° ___ %

ABDOMINAL
1 ☒ normal
2 ☐ distended
3 ☐ rebound
4 ☐ rigidity
5 ☐ tender
6 ☐ nausea
7 ☐ vomit ___

GI/GU
1 ☐ negative
2 ☐ rectal bleeding
3 ☒ diarrhea
4 ☐ dysuria
5 ☐ hematuria

OB/GYN
☐ LNMP ___
☐ preg. ___ mo.
☐ G ___ P ___ AB ___
☐ BOW/2 ☐ BOWR
☐ vaginal bleeding
☐ contractions
freq. ___ duration ___
☐ delivery time ___
☒ APGAR 1 MIN ___
☒ APGAR 5 MIN ___

ENVIRONMENT
1 ☒ home
2 ☐ residential institution
3 ☐ construction site
4 ☐ industrial place
5 ☐ recreational
6 ☐ street/highway
7 ☐ public building
8 ☐ other specific place

NATURE OF CALL
TRAUMA
06 ☐ burn
10 ☐ drowning
35 ☐ fall
21 ☐ GSW
36 ☒ near drowning
27 ☐ muscle/skeletal
04 ☐ MVC
33 ☐ stabbing
39 ☐ other trauma

MVC
41 ☐ driver
42 ☐ passenger front
43 ☐ passenger rear
44 ☐ bike/motorbike
45 ☐ pedestrian
46 ☐ other ___

SEVERITY OF INJURY
1 ☐ possible
2 ☐ non-incapacitating
3 ☐ incapacitating

RESTRAINT/ PROTECTION
1 ☐ seat belt
2 ☐ air bag
3 ☐ helmet
4 ☒ child restraint
5 ☒ protective padding
6 ☐ none

JOB RELATED
☐ yes ☒ no

NATURE OF CALL
MEDICAL
11 ☐ anaphylaxis
22 ☐ cardiac
09 ☐ diabetic
14 ☐ emergency transfer
37 ☐ fever
20 ☐ GI/GU
25 ☐ Ob/Gyn
28 ☐ overdose
29 ☐ poison
02 ☐ possible ETOH
30 ☐ psychiatric
12 ☐ respiratory
07 ☐ seizure
34 ☐ stroke
40 ☒ other ___

AID PROVIDED
31 ☐ AED use
24 ☐ backboard
23 ☐ bandaging
33 ☐ blanket
41 ☐ burn sheet
42 ☐ CID ___
01 ☐ cold packs
21 ☐ control bleed
02 ☐ c-collar ___
20 ☐ CPR
27 ☐ CPR-citizen
15 ☐ cardiovert@ ___
08 ☐ defib.@ ___
14 ☐ drugs
30 ☐ D-stick
11 ☐ ECG ___
18 ☐ ET-size ___
34 ☐ emesis bag
32 ☐ extrication
35 ☐ intraosseous infusion
13 ☐ IV-ga ___ site ___
43 ☐ needle ___
03 ☐ nasal air ___
04 ☐ oral air ___
19 ☐ O_2 ___
26 ☐ other ___
36 ☐ pacing
29 ☐ PASG
05 ☐ physical exam
06 ☐ scoop
16 ☐ splint ___
07 ☐ stretcher
37 ☐ suction
40 ☐ syringe ___
12 ☐ telemetry
38 ☐ temperature
28 ☐ thumper
09 ☐ traction splint
39 ☐ 12-lead ECG

IV SOLUTION
1 ☐ Ringers
2 ☐ D_5W

DRUGS
23 ☐ Adenosine
21 ☐ Act. Charcoal
25 ☐ Albuterol
01 ☐ Alcaine
24 ☐ Aspirin
02 ☐ Atropine
03 ☐ Benadryl
04 ☐ Bretylium
05 ☐ Dopamine
06 ☐ Dextrose
07 ☐ Epi.-1:1000
08 ☐ Epi. 1:10,000
09 ☐ Ipecac
11 ☐ Lasix
12 ☐ Levophed
13 ☐ Lidocaine 1%
14 ☐ Lidocaine 4%
15 ☐ Narcan
16 ☐ Nitronox
20 ☐ Nitrospray
22 ☐ Saline
18 ☐ Sodium Bicarb
17 ☐ Valium
19 ☐ Ventolin

PICK-UP CODES
0 ☐ Transport
1 ☐ False
2 ☐ No Sick/Inj.
3 ☐ DFD Refused
4 ☐ Pat. Refused
5 ☐ Left Scene
6 ☐ Disregarded
7 ☐ Alarm Malf.
8 ☐ Pat. Transferred to ___
9 ☐ Standby

ACT REC CODE
10 ☐ City Wkrs. Comp.
11 ☐ City Prisoner
12 ☐ County Prisoner
13 ☐ Other cities
14 ☐ Hosp-Hosp

COMA SCORE
MOTOR RESPONSE
01 ☐ no response
02 ☐ ext. to pain
03 ☐ flexion to pain
04 ☐ withdraws to pain
05 ☐ localizes pain
06 ☐ obeys comms.
VERBAL RESPONSE
01 ☐ no response
02 ☐ incomprehen. sounds
03 ☐ inappropriate words
04 ☐ disoriented & converses
05 ☐ oriented & converses
EYE RESPONSE
01 ☐ no response
02 ☐ to pain
03 ☐ to verbal
04 ☐ spontaneous
GCS
04 ☐ 13-15
03 ☐ 9-12
02 ☐ 6-8
01 ☐ 4-5
00 ☐ 3
RESP. RATE
04 ☐ 10-29
03 ☐ +29
02 ☐ 6-9
01 ☐ 1-5
00 ☐ 0
SYSTOLIC B/P
04 ☐ +89
03 ☐ 76-89
02 ☐ 50-75
01 ☐ 1-49
00 ☐ 0
21 ☐ ADULT TRAUMA SC. ___

REMARKS: ___

HOSPITAL ___ 1 ☐ Paramedic Choice 2 ☐ Patient Choice Pt Priority 1 ☐ 2 ☐ 3 ☐ Code 1 ☐ 3 ☐ Dr. or RN ___

Paramedic: Emp# [illegible] Emp# [illegible] Emp# ___ Add. Personnel: Emp# ___ Emp# ___ MICU ___ Shift ___ Fire Co # ___ Police# ___

Condition on Arrival at Hospital:
1 ☐ same 2 ☐ improved 3 ☐ deteriorated

WHITE-Fire PINK-SGS Courier YELLOW-Hospital

DFD FORM 200
REV 6/95 DFD-00901

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

CONSENTS AND AUTHORIZATIONS

00 54 55 85 E 10
HEARN, SUSAN DIANNE
AD

CONSENT FOR MEDICAL TREATMENT

I do hereby voluntarily consent to and authorize the Dallas County Hospital District (DCHD) to provide care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the attending physician and/or his/her designees. Initials

AUTHORIZATION TO PAY BENEFITS TO DALLAS COUNTY HOSPITAL DISTRICT

I authorize payment directly to the DCHD of all benefits otherwise payable to me or for me by any third party payor. Initials

I understand I am financially responsible to the DCHD for charges not covered by third party payors. Initials

I understand that I shall be billed separately for professional services rendered by each physician or other health care provider. Initials

I hereby authorize DCHD to release any medical information to any third party payor pertaining to my diagnosis and treatment within the DCHD. This may include, but not be limited to, information concerning communicable diseases, laboratory test results, medical history, treatment progress, or any other such related information requested. Initials

I understand that this authorization is valid for the time period which is consistent with the Medical Record Department policy of the DCHD or until the medial claim has been paid, whichever is longer. Initials

AUTHORIZATION TO RELEASE INFORMATION

I authorize DCHD to confirm my presence and release a one word condition statement, such as, "Critical, Serious, Fair, or Good." Initials

I authorize DCHD to release health care information, including medical history, diagnosis, treatment, or prognosis, to my next of kin and/or the following person. List Names Initials

_____

I have read and understand the above consent and authorizations.

Signature *(Patient, Guardian, or Legally Authorized Representative)* _____ Date 3-3-97

Relationship to patient _____

DCHD Representative/ID Number ST Language Assist./ID Number _____

STATEMENT OF PATIENT LEAVING AGAINST MEDICAL ADVICE

I am the responsible party and am removing the patient, _____ from the Dallas County Hospital District and I hereby assume any and all responsibility for accident and illness attending or following the above named patient's discharge from the Dallas County Hospital District. I acknowledge liability for all incurred expenses.

Signature *(Patient, Guardian, or Legally Authorized Representative)* _____ Date _____

Relationship to patient _____

DCHD Representative/ID Number _____

For DCHD Use Only: _____

E46

PS 845 6/96

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

DEPARTMENT OF EMERGENCY SERVICES
AFTER CARE INSTRUCTIONS

54 55 85 E
EARN, SUSAN DIANNE
AD 03/03/
F 11338 AD
A
10270

IMPORTANT: We have examined and treated you today on an emergency basis only. This is not a substitute for, or an effort to provide complete medical care. In most cases you must let your private doctor check you again. If you have been referred to a clinic, we strongly recommend that you keep your appointment. If you have had special tests such as EKG's, X-rays or labs we will review them again. We will attempt to call you if there are any suggestions. After leaving, follow the instructions listed below.

DIAGNOSIS: Migraine Headache.

MEDICATION:

FOLLOW LABEL INSTRUCTIONS FOR ANY PRESCRIPTION GIVEN BY EMERGENCY PHYSICIAN

☐ TAKE ANTIBIOTICS UNTIL GONE

PREPRINTED INSTRUCTIONS GIVEN: ☐ YES ☐ N/A

IN SPANISH: ☐ YES ☐ N/A

☐ BACTRIM	☐ PENICILLIN
☐ CLOTRIMAZOLE VAGINAL CREAM/TAB	☐ PHENOBARBITAL
☐ DOXYCYCLINE	☐ PREDNISONE
☐ DILANTIN	☐ TETRACYCLINE
☐ ERYTHROMYCIN	☐ TYLENOL #3
☐ IBUPROFEN/MOTRIN	☐ VERAPAMIL
☐ FLAGYL	☐ ZANTAC
☐ KEFLEX	☐ _____
☐ LASIX	☐ _____
☐ ROBAXIN	☐ _____

DEMONSTRATED/PREPRINTED INSTRUCTIONS GIVEN

☐ ABDOMINAL WARNINGS
☐ BURN CARE
☐ CAST CARE
☐ CRUTCH TRAINING
☐ D&C FOLLOW-UP
☐ DRESSING CHANGE
☐ FOOT CARE
☐ HEAD INJURY
☐ SUTURE CARE
☐ WOUND CARE
☐ WET TO DRY DRESSING
☐ OTHER _____

OTHER RESOURCES

☐ DENTAL CLINIC REFERRAL
☐ HEALTH DEPT. REFERRAL
☐ HOMELESS REFERRAL
☐ SOCIAL SERVICES REFERRAL
☐ FAMILY PLANNING REFERRAL

SPECIAL INSTRUCTIONS: Take medications as prescribed. Follow up with ACC on 3/30/97 call 590-5515 for an appointment. Return to Emergency as needed for any return of symptoms. Neurology will call you with your appointment.

FOLLOW-UP/CLINIC APPOINTMENT GIVEN ☐ YES ☐ N/A **PRESCRIPTION GIVEN:** ☐ YES ☐ N/A

I HAVE RECEIVED AND UNDERSTAND THE INSTRUCTIONS ABOVE. I UNDERSTAND THAT I HAVE HAD EMERGENCY TREATMENT ONLY. I WILL ARRANGE FOR FOLLOW-UP CARE AS INSTRUCTED AND I WILL CAREFULLY FOLLOW THE INSTRUCTIONS GIVEN.

TRANSLATOR USED: ☐ YES ☐ N/A

DISCHARGED: ☐ HOME ☐ OTHER _____

☐ AMBULATORY ☐ WHEELCHAIR ☐ OTHER _____

(X) Susan Johnson
PATIENT/SIGNIFICANT OTHER SIGNATURE

RN/MD SIGNATURE: _____ DATE: _____ TIME: _____

UNAVAILABLE FOR DISCHARGE TEACHING: 1) _____ TIME / INITIAL 2) _____ TIME / INITIAL 3) _____ TIME / INITIAL

006A

PS 149 Revised 9/92 White Copy - Medical Record Yellow Copy - Patient's Copy

DALLAS COUNTY HOSPITAL DISTRICT
EMERGENCY DEPARTMENT ADMISSION

T DATE	ADMIT TIME	ER MD	SERVICE
11/12/96	07:37	10801	4020

PATIENT

LAST	FIRST	MIDDLE	MAIDEN	ACCOUNT #	MR #
RN,	SUSAN	DIANNE	ROSS	000114136237	000000545585

ADDRESS	APT #	CITY	STATE	ZIP	COUNTRY
[redacted]T		DALLAS	TX	75204 - 6738	057

PHONE	BIRTH DAY	AGE	SEX	RACE	MAR STAT	SOC SEC #	REFERRING PHYSICIAN OR MEDICAL FACILITY	ARR MEANS	CRIME VICTIM	POLICE NOTIF
214-827-5988	[redacted]	036	F	BL	P	[redacted]		SE		

AMBULANCE #	TYPE	LOCATION OF ACCIDENT	ACCIDENT DATE	ACC TIME

EMPLOYER

EMPLOYER	EMPLOYER ADDRESS
NONE	

EMPLOYER CITY	STATE	ZIP	EMPLOYER PHONE	EXT	WRK REL
		- 0000			

GUARANTOR

GUARANTOR'S NAME	GUARANTOR'S ADDRESS	APT. #
HEARN, SUSAN DIANNE	[redacted]	

GUARANTOR'S CITY	STATE	ZIP	PHONE - HOME
DALLAS	TX	75204 - 6738	214-827-5988

GUARANTOR'S EMPLOYER	PHONE - BUSINESS	RELATIONSHIP TO PATIENT
NONE		SELF

NEXT OF KIN

NEXT OF KIN	NEXT OF KIN - ADDRESS	PHONE - HOME
SHEPPARD, MARY	[redacted]	214-827-5988

NEXT OF KIN - CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	PHONE - BUSINESS
DALLAS	TX	75241 - 0000	FRIEND	000-000-0000

CONTACT

LOCAL CONTACT	LOCAL CONTACT ADDRESS	PHONE - HOME
SHEPPARD, MARY	[redacted]	214-827-5988

LOCAL CONTACT - CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	PHONE - BUSINESS
DALLAS	TX	75241 - 0000	FRIEND	

INSURANCE

INSURANCE COMPANY	CO/PLN	GROUP NAME	GROUP #	PLAN CODE
TAX SUPPORTED PR	10/001	N / A	N / A	N/A

EFFECTIVE DATE	NAME OF INSURED	I.D. #	AUTHORIZATION #	CERT DATE
/ /	HEARN, SUSAN DIANN		N / A	

DX

PROBLEM/CHIEF COMPLAINT	COND	S1	S2	S3	LAST DC DATE	FIN CLS	ADM BY
DIZZINESS OR WEAKNESS	2	A				10	ST

CONSENT FOR TREATMENT/RELEASE OF RESPONSIBILITY FOR VALUABLES

I grant permission to the medical staff of the Dallas County Hospital District to perform any medical or surgical treatment and to administer such anesthestics and/or drugs as may be deemed necessary in the diagnosis and treatment of said patient. Futhermore I state that all patient information is true and correct to my personal knowledge, I also release the Dallas County Hospital District from all responsibility for any valuables and personal articles that are not checked in by the hospital staff.

SIGNED: _____ RELATIONSHIP IF OTHER THAN PATIENT IS SIGNING: _____

WITNESS: _____ TIME: _____

LEAVING AGAINST MEDICAL ADVISE

I am the responsible party and am removing the patient, _____ , from the Dallas County Hospital District and I hereby assume any and all responsibility for accident and illness attending or following the above named patient's discharge from the above named institution. I acknowledge liability for all incurred expenses, including all Emergency Room fees.

SIGNED: _____ RELATIONSHIP IF A MINOR: _____

MD SIGNATURE: _____ DATE: _____ TIME: _____

TEMPORARY ABSENCE RELEASE

I have obtained permission from the attending physician to be absent from the Emergency Dept. for my convenience from:

TIME: _____ DATE: _____ to TIME: _____ DATE: _____

I assume all responsibility for the named patient, during this temporary absence and hereby release the Dallas County Hospital District, its employees and the attending physician from all responsibility during this absence and for my or the patient's condition as a result thereof.

SIGNED: 340.90 RELATIONSHIP IF A MINOR: _____

MD SIGNATURE: _____ DATE: _____ TIME: _____

FORM 580002 REV 12/01 O: I: E:

MEDICAL RECORD

(6)

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

DEPARTMENT OF EMERGENCY SERVICES
PHYSICIAN REPORT

00 54 55 85 F
HEARN, SUSAN DIANNE
011413627 AD
[redacted] F 11336
[redacted]
10801

ALLERGIES: NKA

INITIAL VITAL SIGNS TIME: 0650 T 37.4 P 100 R 20 BP 134/106

COMPLAINT: H/A x 2d

PHYSICIAN NOTES TIME SEEN: ______

36 y/o BF c̄ ∅ PMH who presents c̄ (R) sided weakness x 3days. Claims HA (intermittent) x 3d. Also claims ~~slurred~~ difficulty speaking this AM that has resolved. Denies N/V/fever/cough/CP. States having numbness on the (R) side of her face. Pt states that she experiences these Sx c̄ migraine HA.

Gen: in NAD
Chest: RRR
Lungs: CTA (B)
Abd: BS ⊕, NT, ND, soft
Ext: ∅ C/C/E
HEENT: NC/AT, PERRL, EOMI
Neuro: alert, oriented x3; ...
Motor RUE 3/5 RLE 4/5
LUE/LLE 5/5
Head CT: ⊖

Soc Hx: Tob - 3 packs/wk x 1840
EtOH ∅
IVDA ∅
BTransf ∅
Meds ∅
Allerg: NKDA
PMH: ∅

Tbil .3
AST 16 ALT 13
Alb 27 Glu 78
TP 7.2 alk 44

Labs: 12.7 / 210 (10.1 / 37.7)

70 P 24 L 4 M

PT 12.3 / PTT 25.3 — 141 | 108 | 11 / 82; 3.9 | 27 | .7; 9.3 / 3.5 / 1.5

EKG: NSR @ 71 bpm ∅ ST/TW Δs.

@ 1420 Neurological exam non-focal; Motor 5/5 (B) UE/LE
Pt evaluated by Neuro Svc and their impression is that clinical picture was c/w Migraine HA and will follow their recommendation.

☐ SEE CONT. SHEET

LAB/RADIOLOGY ORDERS (CIRCLE)

~~CBC DIFF~~ UA ~~GLU~~ ~~CREAT~~
~~PT PTT~~ ABG RPR TOX
CARDIAC ENZYMES ~~LIVER BATTERY~~
~~CA~~ ~~MG~~ ~~PO4~~ I&C ______
ETOH AMYLASE G&S
~~LYTES BUN~~ EKG
OTHER: ______
X RAY: ______

TIME	ORDERS
done	Hep-lock IV
	Fioricet 2 tabs PO, now
	D/C above
done	Thorazine 50 mg IV slowly

CONSULT/ADMIT SERVICES

SERVICE	TIME CALLED	TIME IN DEPT.

DIAGNOSIS: Migraine HA

DIAGNOSIS CODE:

MD SIGNATURE: [signature]

MD PRINTED NAME: Bonk

FACULTY SIGNATURE: [signature]

DISCHARGE PLAN / RX GIVEN / FOLLOWUP: (1) Midrin as indicated (2) Elavil 25mg qhs ~~...~~ (3) Lortab (4) Phenergan ... prn (5) Neuro Clinic F/U appt as scheduled by Neuro Svc.

DISPOSITION: ☒ HOME ☐ AMA ☐ AWOL ☐ ADMIT (SERVICE:) TRANSFER TO:

CONDITION: ☒ IMPROVED ☐ UNCHANGED ☐ EXPIRED TIME ______ AM PM DATE: ______

005

35600 Revised 12/91

MEDICAL RECORDS

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

CONSENTS AND AUTHORIZATIONS

00 54 [redacted] F
HEARN, SUSAN DIANNE
[redacted]

CONSENT FOR MEDICAL TREATMENT

I do hereby voluntarily consent to and authorize the Dallas County Hospital District (DCHD) to provide care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the attending physician and/or his/her designees.

Initials

AUTHORIZATION TO PAY BENEFITS TO DALLAS COUNTY HOSPITAL DISTRICT

I authorize payment directly to the DCHD of all benefits otherwise payable to me or for me by any third party payor.

Initials

I understand I am financially responsible to the DCHD for charges not covered by third party payors.

Initials

I understand that I shall be billed separately for professional services rendered by each physician or other health care provider.

Initials

I hereby authorize DCHD to release any medical information to any third party payor pertaining to my diagnosis and treatment within the DCHD. This may include, but not be limited to, information concerning communicable diseases, laboratory test results, medical history, treatment progress, or any other such related information requested.

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I understand that this authorization is valid for the time period which is consistent with the Medical Record Department policy of the DCHD or until the medial claim has been paid, whichever is longer.

Initials

AUTHORIZATION TO RELEASE INFORMATION

I authorize DCHD to confirm my presence and release a one word condition statement, such as, "Critical, Serious, Fair, or Good."

Initials

I authorize DCHD to release health care information, including medical history, diagnosis, treatment, or prognosis, to my next of kin and/or the following person. List Names

Initials

_____

I have read and understand the above consent and authorizations.

X Susan Dianne Hearn — 11-13-96

Signature *(Patient, Guardian, or Legally Authorized Representative)* — Date

Relationship to patient _____

DCHD Representative/ID Number ST 11338 — Language Assist./ID Number _____

STATEMENT OF PATIENT LEAVING AGAINST MEDICAL ADVICE

I am the responsible party and am removing the patient, _____ from the Dallas County Hospital District and I hereby assume any and all responsibility for accident and illness attending or following the above named patient's discharge from the Dallas County Hospital District. I acknowledge liability for all incurred expenses.

_____ — _____

Signature *(Patient, Guardian, or Legally Authorized Representative)* — Date

Relationship to patient _____

DCHD Representative/ID Number _____

For DCHD Use Only: _____

_____

E46

PS 845 6/96 — 90 Day Trial — *White - Chart* — *Yellow - Business Services*

INPATIENT–FILE WITH ADMINISTRATIVE RECORDS ON FRONT CLIP

DALLAS COUNTY HOSPITAL DISTRICT

DALLAS, TEXAS

WORK/SCHOOL RELEASE AND APPOINTMENT VERIFICATION

98 NOV 25

00 54 55 85 E 10
HEARN, SUSAN DIANNE
0114136237 AD 11/12/96
[redacted] BL F 113R 40:0

APPOINTMENT VERIFICATION

This is to indicate that _____

has been seen in the _____ (TREATMENT AREA) of Dallas County Hospital District on _____ (DATE)

_____ RN
PRINTED NAME

_____ RN
SIGNATURE

Date: _____

MEDICAL RELEASE/RESTRICTIONS

No work Today & Tomorrow 11-12/11-13
back to work on 11-14

This patient is considered ready to return to work/school on _____

D TEMPLETON MD
PRINTED NAME

D. Templeton MD
SIGNATURE

Date: 11-12-96

OUTPATIENT–FILE BEHIND SOCIAL HISTORY RECORDS ON FRONT CLIP

N35

FORM NO. 52620 (REV. 9/87) WHITE COPY – CHART YELLOW COPY – PATIENT

HEARN, SUSAN ID: 000545988 12-Nov-1990 9:42:56 FAIRBANKS MEMORIAL HOSPITAL

36years
Female Black

Room: C
Loc: 76 Opt: 9

Vent. rate 71 bpm
PR interval 176 ms
QRS duration 92 ms
QT/QTc 378/411 ms
P-R-T axes 52 83 60

Normal sinus rhythm
Minimal voltage criteria for LVH, may be normal variant
Borderline ECG

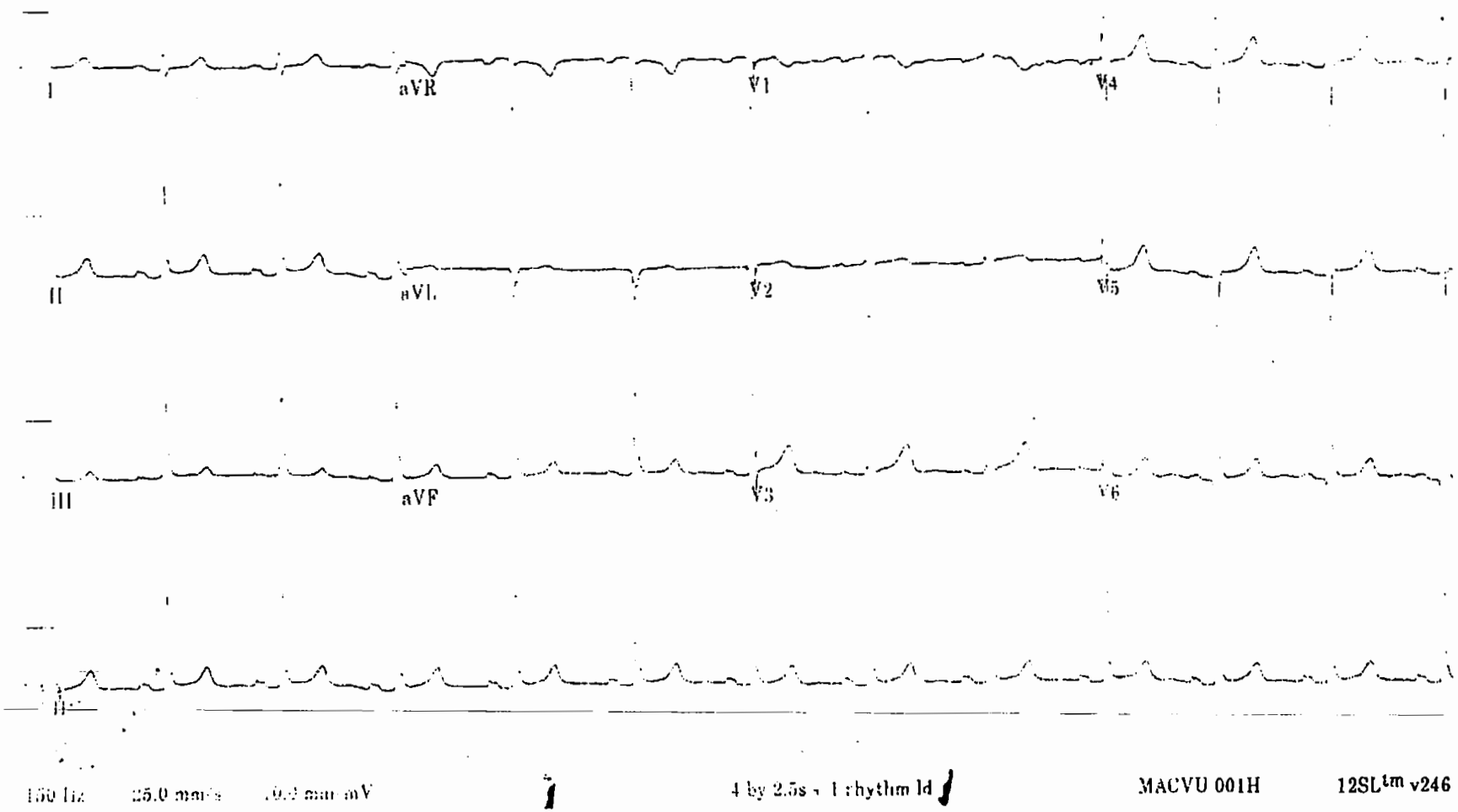
[redacted]
History: Unknown
Technician: 09
Test ind: UNK

Referred by:

Unconfirmed

stat: Yes

rhy strip: No



150 Hz 25.0 mm/s .0/ mm/mV 4 by 2.5s + 1 rhythm ld MACVU 001H 12SL^{tm} v246

DALLAS COUNTY HOSPITAL DISTRICT
DALLAS, TEXAS

CONSULTATION SHEET

00 54 55 85 E 10
HEARN, SUSAN DIANNE
[redacted] AL

Hearn, Susan Dianne.

Department Requesting Consultation: Date and Hr.

Department Giving Consultation:

Tentative Diagnosis:

Pertinent History:

M.D.

Consultant's Note:

Date, Hour: 11/12/96 at 9[45] AM.

Reqest handed:

36 Y.O.B.F, c̄ H/O Migraine headache, since 1970s, who gets headache, almost twice a week, every time she has Right side numbness with it.

This time her headache started on Saturday with throbbing headache, bifrontal, with blurred vision. Photophobia, & Right side numbness, with heaviness in her tongue, but no nausea, vomiting, or weakness. No dizziness, vertigo, passing out, or chest pain.

She took Midrin for her headache, 5 on Sat., 5 on Sund, & 2 yesterday, which helped in ↓ing her headache but not releave it. She run out of her Meds so she came.

She is not on any Prophelactic Medication.

She does not know any factors which provoke her symptoms, except of stress.

PMH: - Hysterectomy in 1978 (her headache got worse after that)
- Migraine headache

S. Kafi
Signature

070

FORM NO. 50500 (REV. 9/70)

CONSULTATION SHEET

Personal :- Smoker 15 cig / days x Many years.
- Ø Drugs or Alcohol.
- Used to Abuse drugs, was on rehab Program in the Past.
- Single Lives in shelter, worked in Dallas morning news, but news paper delivery.
her son Lives with her sister

Meds : Midrin PRN.

Family : Father Died b/o Cancer. ? Pleural Mother ? Heart Disease + DM.
2 Sisters have Migraine headache one of them pass out with every headache.

P/E : Alert x4, heavily speech, Neck is supple. General Exam Unremarkable.
Neuro : cranial nerves : II - XII were intact, no papilledema or nystagmus except decreased sensory on the Right face.
Motor : 5/5 all over.
DTR : ++ all over, with, downgoing toes
Sensory : Numb. on the Right with decreasing sensation on the Right.
finger - nose, heel - shin, & gait were normal, no Ataxia.

CT - head, ± contrast : neg.

Impr : Complicated migraine.
- Imitrex & ergot is contraindication.

Plan :- Fioricet 2 tab PO now, then q 4 hrs PRN X 30 tabs
- if those 2 tabs now did not relieve her headache, Thorazine 50 mg, IV slowly can be given.
- Continue her Midrin on PRN basis
- Start Elavil 25 mg PO QHS, can be ↑ to 50 mg QHS in 4-5 days if she tolerates it.
- We will follow her up in Neuro clinic.
- From Neurologic Point of view can be D/C home.

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

EMERGENCY SERVICES DEPARTMENT
MEDICINE PATIENT ASSESSMENT FORM

Heart

INITIAL ASSESSMENT TIME: 0950 DATE: 11-12-99 ARRIVED: AMBULATORY ✓ NON-AMBULATORY ____

ALLERGIES: NKA

CHIEF COMPLAINT: Headache x 2 days

LEVEL OF CARE (circle) (1) 2 3 4 5

NURSING ASSESSMENT: Pt. states has had HA x 2 days, Midrin has been effective in relief of headache. Pt. states she lost her speech yesterday AM and did not regain it until this AM, states tongue is numb and face is numb. Pt denies other neurological deficits

VITAL SIGNS

TIME	B/P	TEMP	PULSE	RESP/O_2SAT	D-STIX	INIT.
0950	138/86	37.4	100	20		
1130	118/70	37°	72	20		SA
1500	92/60	37°	88	24		SA

PATIENT VALUABLES / BELONGINGS

With Patient ____ With Family ____ Cashier ____

IMMUNIZATIONS REVIEWED: YES ____ NO ____ N/A ✓

IMMUNIZATION REFERRAL SHEET GIVEN: YES ____ NO ____

MEDICAL HISTORY (+) YES (-) NO

—	CARDIAC	—	HTN
—	COPD/ASTHMA	—	RENAL
—	DIABETES	—	IDP
—	SEIZURE DISORDER	—	OTHER (describe)

PATIENT REFERRALS

TYPE:

INTAKE

TIME	#IV	SITE	GAUGE	TYPE FLUID	VOLUME/TOTAL	INIT.
0945	1	(R) AC	20	NS	A lush	LH

CURRENT MEDICATIONS

Midrin

INTAKE

TIME	TYPE	VOLUME/TOTAL	INIT.

PATIENT RESPONSE

PREGNANT: ☐ YES ☑ NO ☐ UNK ☐ N/A

SIGNATURE / ID #: [signature] /1599 , R.N.

MEDICATIONS ADMINISTERED

DRUG	DOSAGE	ROUTE/SITE	TIME	PLUG FLUSHED	INIT.
Maxzine	30 mg/50 NS	IV	1130	NS	SA

RN / LVN / PCT INITIALS / ID #: SA ID # 1599 SA ID # 13675 SK ID # 12002 ____ ID # ____

SIGNATURE: [signature] [signature] [signature] ____

006

PS 599 Rev. 7/95 White Copy - Chart Yellow Copy - Faculty Pink Copy - Management

DALLAS COUNTY HOSPITAL DISTRICT

DALLAS, TEXAS

EMERGENCY ROOM RECORD

CONTINUATION

NAME: Last First Middle

Emergency Room Number: Date

Time Ordered	Medications and Treatments (continued)
0801	pt going to C.T - (SA)
0820	brought pt back from C.T-(SA)
0945	Heplock placed (R) AC, labs drawn from site.
	Flushed c̄ 5cc NS saline. Taped Securely in Place.
	∅ Infiltration or redness noted. — E. Haynisher 1367
1130	IV Thorazine started. Diluted in 50cc/NS
	on Baxter pump @ 350cc/hr. — E. Haynish
1150	Waiting on labs. Pt. Continues C/O HA. ↑ to
	Bathroom. Tolerated well — E. Haynisher
1518	Pt on side hall - sleeping. Awakens to
	voice & light stimulation. Meds effective for
	pain. Pt groggy so ride called to pick
	up pt. Will review D/C orders when ride arrives.
	[illegible signature]
1615	Pt d/c'd c̄ ride home d/t grogginess. Given
	prescript for Midrin / Lortab. IV d/c'd - Cannula intact [illegible] 1232
1620	Fioricet not given d/ PMH. Lortab given c̄ instructions by Pharm
	re: directions of meds. Pt Gait steady. Keys unlabored [illegible] 1232

006

FORM NO. 55090 (REV. 2/77)

DALLAS COUNTY HOSPITAL DISTRICT
Dallas, Texas

DEPARTMENT OF EMERGENCY SERVICES
AFTER CARE INSTRUCTIONS

82-9192
Parent
Carolyn

CO 54 55 85 E 10
HEARN, SUSAN DIANNE
011413627 AD 11/12/96
[redacted]

IMPORTANT: We have examined and treated you today on an emergency basis only. This is not a substitute for, or an effort to provide complete medical care. In most cases you must let your private doctor check you again. If you have been referred to a clinic, we strongly recommend that you keep your appointment. If you have had special tests such as EKG's, X-rays or labs we will review them again. We will attempt to call you if there are any suggestions. After leaving, follow the instructions listed below.

DIAGNOSIS: Migrane Headache

MEDICATION:

FOLLOW LABEL INSTRUCTIONS FOR ANY PRESCRIPTION GIVEN BY EMERGENCY PHYSICIAN

☐ TAKE ANTIBIOTICS UNTIL GONE

PREPRINTED INSTRUCTIONS GIVEN: ☐ YES ☐ N/A

IN SPANISH: ☐ YES ☐ N/A

☐ BACTRIM	☐ PENICILLIN
☐ CLOTRIMAZOLE VAGINAL CREAM/TAB	☐ PHENOBARBITAL
☐ DOXYCYCLINE	☐ PREDNISONE
☐ DILANTIN	☐ TETRACYCLINE
☐ ERYTHROMYCIN	☐ TYLENOL #3
☐ IBUPROFEN/MOTRIN	☐ VERAPAMIL
☐ FLAGYL	☐ ZANTAC
☐ KEFLEX	☑ Florinal
☐ LASIX	☐
☐ ROBAXIN	☐

DEMONSTRATED/PREPRINTED INSTRUCTIONS GIVEN

☐ ABDOMINAL WARNINGS
☐ BURN CARE
☐ CAST CARE
☐ CRUTCH TRAINING
☐ D&C FOLLOW-UP
☐ DRESSING CHANGE
☐ FOOT CARE
☐ HEAD INJURY
☐ SUTURE CARE
☐ WOUND CARE
☐ WET TO DRY DRESSING
☐ OTHER _____

OTHER RESOURCES

☐ DENTAL CLINIC REFERRAL
☐ HEALTH DEPT. REFERRAL
☐ HOMELESS REFERRAL
☐ SOCIAL SERVICES REFERRAL
☐ FAMILY PLANNING REFERRAL

SPECIAL INSTRUCTIONS: Midrin as indicated
Elavil 25mg at bedtime
Neuro Clinic Follow up as scheduled by Neuro Service

FOLLOW-UP/CLINIC APPOINTMENT GIVEN ☐ YES ☐ N/A **PRESCRIPTION GIVEN:** ☑ YES ☐ N/A

I HAVE RECEIVED AND UNDERSTAND THE INSTRUCTIONS ABOVE. I UNDERSTAND THAT I HAVE HAD EMERGENCY TREATMENT ONLY. I WILL ARRANGE FOR FOLLOW-UP CARE AS INSTRUCTED AND I WILL CAREFULLY FOLLOW THE INSTRUCTIONS GIVEN.

TRANSLATOR USED: ☐ YES ☑ N/A

DISCHARGED: ☑ HOME ☐ OTHER _____ (x) Susan Hearn
PATIENT/SIGNIFICANT OTHER SIGNATURE

☑ AMBULATORY ☐ WHEELCHAIR ☐ OTHER _____

RN/MD SIGNATURE: [signature] DATE: 11/12 TIME: 1500

UNAVAILABLE FOR DISCHARGE TEACHING: 1) _____ TIME/INITIAL 2) _____ TIME/INITIAL 3) _____ TIME/INITIAL

006A

PS 149 Revised 9/92 White Copy - Medical Record Yellow Copy - Patient's Copy